

Qi

氣

2005

老人如同風前燭



Annual Publication of the
Australian Chinese Medical Association (Vic.) Inc.

Editor: Siew-Khin (Happy) Tang

Co-Editor: Elaine Wei-Tinn Chong

Qi

氣 2005

Qi ('chi') is the pinyin version of 氣 which is regarded as the life-force or pervasive vital energy which animates us.

The ACMAV logo depicts a Chinese dragon intertwined with the traditional serpent and staff.

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ACMAV Inc. was founded in 1985 as the Chinese Medical Society, with Dr Tom Tsiang as Foundation President; it became the ACMAV in 1987. The inaugural edition of the *Qi* gazette was published by Dr Joseph Cheung in 1991.

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Annual Publication of the
Australian Chinese Medical Association (Vic.) Inc.

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燭火在微風中輕舞，卻在大風中熄滅。

A man's life is likened to a candle - a gentle breeze revitalises its flame; a strong wind snuffs it out.

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Editorial



The past year has been rewarding and successful, with many projects completed and targets achieved. Education seminars and entertainment evenings for our elderly citizens were well attended and well received. These sessions were enjoyed by all who organised or participated, and the committee should be congratulated on this achievement.

Overseas aid projects and organisational facilities in Melbourne, for treatment of overseas patients, have continued with great success. This is well illustrated in the successful outcome of a Vietnamese infant with congenital abnormalities of the face; she was treated at the Royal Children's Hospital. An account of the remarkable surgical procedure is recorded in the article under Overseas Aid. Hopefully such programmes will continue in the years ahead, funds permitting.

The travelogue has included interesting places visited by our members. Even in this current climate of global instability (economic and political), we should not be hampered in our travels and continue to experience different cultures, learn to respect issues of sensitivity in different nationalities, religions and alternative life-style preferences.

Our roving culinary critique and chef have included recommendations and an age-old recipe to challenge us in areas we would otherwise not venture to. I would encourage other members to share their culinary expertise with us.

Our members are now informed of our ACMAV Foundation which will continue to fund overseas aid programmes, scholarships and medical research. Issues related to the future of ACMAV House will be discussed and debated at coming meetings. The ACMAV continues to attend and socialise with our Vietnamese colleagues of the Vietnamese Australian Medical Association of Victoria at medical seminars. Their contribution in raising funds for our overseas aid programme is acknowledged with appreciation.

This year I have chosen Men's Health and Geriatrics as the theme for our publication. We are fortunate to benefit from the contributions from our overseas and interstate colleagues, and members who unstintingly contribute effort and time to submit articles pertaining to their fields of interest. The 'macho men don't cry' image in males has lost some of the appeal in present day situations. Men are now encouraged to seek advice, counselling and even treatment for ailments they would previously have chosen to ignore. Men are now regarded as caring, dependable mates or fathers and their illnesses are viewed with compassion and sensitivity.

With age comes realisation of life's achievements, responsibilities and, unfortunately, also vulnerability to life's wear and tear. We are now more conscious of health issues. We should be encouraged to enjoy whatever time that remains, in a healthy state of mind and in a pleasant environment.

*“Use your eyes as if tomorrow you would be stricken blind.
Hear the music of voices, the song of the bird, the mighty strains
of an orchestra, as if you would be stricken deaf tomorrow.
Touch each object you want to touch as if tomorrow your tactile
sense would fail.
Smell the perfume of flowers, taste with relish each morsel, as if
tomorrow you could never smell and taste again.
Make the most of every sense; glory in all the facets of pleasure
and beauty which the world reveals to you.”
Helen Keller, “Three days to see”, Atlantic Monthly, 1933.*

Siew-Khin (Happy) Tang

Foreword



While acknowledging the need for greater concern, funding and awareness in many aspects of health care - especially women's and Indigenous health care - there is no doubt the health of men and boys must be seen as a priority for governments, and the medical profession.

It is certainly a deep personal and professional concern of mine, and an area I constantly fought for and supported during my time as AMA President. The statistics show men - particularly young men - are facing more and more complex mental health problems. The community and the medical profession must overcome the socialisation of males that forms the basis of their health concerns.

Risky behaviours like smoking, drinking and taking risks on the road, the sports field or the workplace take a heavy toll on men. These behaviours are often formed by ethnicity, sexual and cultural identity, and age. There are many positive aspects to risk taking behaviour that as a society we rely on. These can be seen in the actions of soldiers, fire fighters, policemen and footballers on the playing field. This brings up one of the complexities in relation to men's health - we encourage men to be risk takers yet their health suffers because of this social requirement to do so.

The largest barrier to improving men's health is that our health system focuses on disease and the approaches to preventing harm is fragmented, underdeveloped and under funded. Funding for public health strategies such as prevention and harm minimisation constitutes only 2% of health budgets.

I am particularly concerned about the rise in mental health problems for men, especially the despair that leads to the high suicide rates for rural and indigenous men. We have to deal with the root of the problem. Research shows that suicide is motivated by relationship failure, alcohol and financial problems. These issues relate in some way to the threat to identity that many men feel as they try to come to terms with their changing role in society, which has significantly altered the traditional concept of men as primary breadwinners.

Women are rightly demanding and achieving more choice about the way they manage their lives, but for men, establishing a new identity can be confusing and challenging. The 'rules' have changed, but the employment and social contexts are not supportive enough as yet to give men the flexibility they need to fulfil new roles. For example, how many men have access to paternity leave? Almost 50 per cent of marriages end in divorce and women initiate the majority of divorces. Men are often left feeling bewildered and disempowered.

Relationship failure is a significant cause of depression and suicide among men. This is not new, but the incidence is increasing. To overcome the feeling many men have - being left on their own - we need to create a more hopeful, nurturing and forgiving society for everyone. The systems have to create new opportunities, especially as the population ages. Financial concerns are the highest stated reason for suicide.

It used to be reasonable to expect financial security. Get a good job, work hard, earn enough money to plan our lives, buy a house, and have kids. But a changing culture in the workforce is affecting men's health. Once, you got a job and you kept it for life, often staying with the same company and leaving after 40 years. But increasingly, people have casual or contract-based employment. We no longer have the luxury of job security enjoyed by our fathers.

The dollar drives a hard bargain. There is not much room for loyalty or compassion. Early retrenchment in middle age is a reality for many men. Good jobs are hard to find for this ageing and often unhealthy group of people. Many young men have never had a permanent job. They probably have no rights - no holiday pay, no sick pay, and no job security. It's difficult to plan for the future, to plan families, housing and have the flexibility to achieve aspirations. Many people have multiple jobs. The stress experienced by men in this situation is enormous.

Poverty brings more than just financial disadvantage. We know the clear connection of poverty to ill health – cancer, diabetes, cardiovascular disease, respiratory diseases. The list goes on. When we discuss health, how often do we take into account the wellbeing created by work, the identity and self-respect it brings, and the ability to fulfil the expectations society has for us?

The second most common cause -or at least in connection with suicide - is alcohol. It is seen and portrayed as an integral part of Australian life, but alcohol impacts negatively on males in our community - especially young males. 15 per cent of males over 14 years old drink at risky levels at least monthly. Males have consistently higher rates of alcohol-related deaths and hospitalisations than females. It is estimated, for example, that in Australia, males accounted for approximately 70% of alcohol-related deaths, 74% of the alcohol-related hospital admissions for violence, and 86% of alcohol-related suicides. I haven't even mentioned the catalogue of health conditions like cardiovascular disease and stroke, which are associated with excessive alcohol consumption.

Young men are a valuable part of our community. We can't afford this waste of young men – the lost opportunities for them, their families and for Australian society. The medical profession can contribute to men's health in the clinical setting by providing a context and environment which men find safe and responsive. It means having an understanding of the epidemiology of disease or conditions in the area and the determinants of health for the person and the area. For example, if there is a high level of chronic disease, doctors should consider what environmental factors might be contributing. Research has shown that men often have a functional view of their bodies, which means that they don't attend to their health needs until it starts to influence their function - be it in relation to work, sexual performance or social interaction. This often results in men taking their health for granted until such time as their functional status is compromised. This has obvious implications for the provision of screening programs and health promotion activities. As doctors, we need to be aware of this fact and incorporate into our dealings with patients. We need to be aware of the different stages men go through developmentally, and how it effects their interaction with us as a medical profession.

As a young man progresses through adolescence, concerns about sexuality, sexual orientation, body image, mental health, arise and risk taking and experimentation may occur at this time. General practitioners have a critical role to play

in helping to guide young men through this challenging period.

A frequent time of re-contact with health services occurs when men embark on parenthood. This is a health watershed with many men re-evaluating their health and gaining much from family life, while at the same time responsibilities and commitments – like a mortgage - increase with subsequent time and relationship pressures. Poorer health can result from reduction in leisure time and physical activity due to the double demands of increased working hours - to boost income - and time spent with children. Research show that from 45 years of age, men begin to start going back to their general practitioner more regularly, however by this stage the problems managed are more chronic in nature. Many of the unhealthy behaviours in youth, such as poor diet, inadequate exercise, and excessive alcohol consumption, begin to show up in increased rates of obesity, diabetes, hypertension and cardiovascular disease. For those men who are working, a significant influence on their health at this age are occupational hazards and stress. Unemployment, being single and/or poor are significant determinants of poorer health.

Sexual health problems, including erectile dysfunction, mental health problems - often as a consequence of changing employment status or relationship breakdown - and prostate cancer are important issues that general practitioners need to be aware of in this age group.

Despite moving into old age, men seem to be no more aware of how to handle health problems. It has been reported that difficulties in adjusting to new roles associated with ageing, including carer health issues, may have an effect on men's health. Male suicide rates are greater for men than women across all age groups, however there is a marked peak within the elderly population of men. The higher rates could be associated with the social isolation that men often face when their spouse dies, as research suggests that men are less resilient under these circumstances than women. And alarmingly, 25% of men over the age of 75 *do not* attend their GP once or more per year. Doctors can and should put men of all ages in touch with networks and support groups.

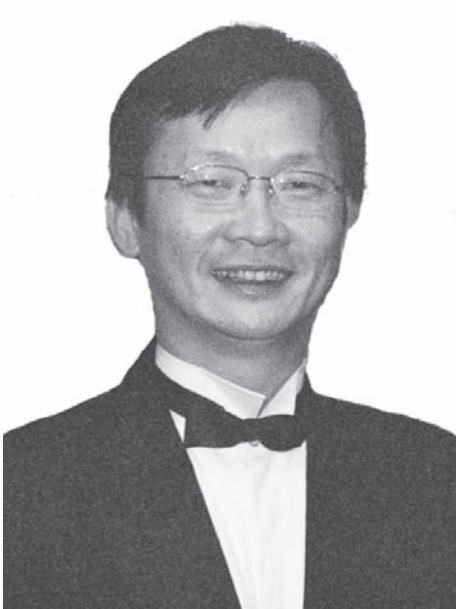
The AMA, and myself personally, want a federally funded, national Men and Boys' Health Program. We have seen the positive results of affirmative action for girls.

Strong strategic action for boys and men is needed. Now!

William Glasson

Federal President of AMA (2003 - 2005)

President's Report



The 2005 Year of the Rooster has been a very successful one for our Association, demonstrating maturity by consolidating what has been tried and true, as well as gaining the confidence to undertake new ventures. The core of our activity has been the series of educational evening seminars which have covered topics as diverse as Multiple Sclerosis, Diabetic Retinopathy, Obesity and Sleep Apnoea. Not deviating from the norm, these have been of high quality with excellent speakers, good venues and adequate opportunities for interaction between speakers and members. We have also had a series of community education health talks to Chinese senior citizens organized by Lawrence Wu which have been very well received. Siew-khin (Happy) Tang our editor and member has also given a talk on Cervical Cancer and Human Papilloma Virus (HPV) vaccine to members of the Chinese Women's Association of Victoria.

The highlight of the year has been our Annual Conference in June, co-hosting the national congress with the ACCMA. The outstanding scientific and social program put together by our congress convenor Kevin Siu and the conference subcommittee set a new mark which is the envy of our interstate and trans-Tasman colleagues. It was an appropriate way to commemorate our 20th anniversary of our Association.

Our new venture this year has been our initiation into overseas medical aid projects, with the sponsoring of a Vietnamese child Tuong Van, who was brought to Melbourne to have corrective surgery at the Royal Children Hospital for repair of her encephalocele. It is through Theong Low's contacts and organizational skills that we have been able to facilitate this important work. It was heartening for me to see the joy on the faces of this little girl and her mother before they left to go home to Vietnam. It also highlighted for me the potential for good work that can be done by the ACMAV and the challenges which lie ahead. This program of humanitarian aid work, started by my predecessor Benny Foo, needs to be incorporated as a continuing aid programme of this Association. It is a sign of our maturity that, while maintaining our core activities, we can successfully undertake these new ventures which in time will become part of our core work.

Apart from the names already mentioned, the Association has had a talented and hardworking committee with Elaine Chong, Mee Yoke Ling, Erwin Loh, Salena Ward, Jun Yang and Nicole Yap providing outstanding service. Special commendation also needs to be given to our editor Happy Tang and her co-editor Elaine Chong, who have worked hard to bring together this issue of our flagship publication.

I wish you a happy and prosperous Year of the Dog in 2006.

Frank Thien



Australian Chinese Medical Association (Vic.) Inc.

COMMITTEE 2005



**Frank Thien
President**



**Mr Kevin Siu
Vice-President**



**Erwin Loh
Secretary**



**Lawrence Wu
Treasurer**

COMMITTEE 2005



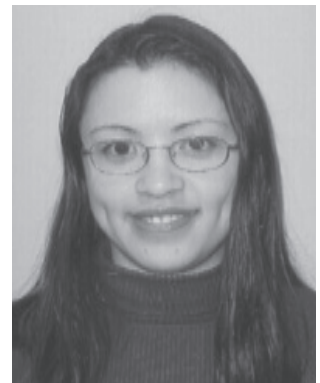
Mee Yoke Ling



Theong Ho Low



Ferry Rusli



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Secretary's Report

It's amazing how time flies. It's been almost a year since I started as the new Secretary of our Association. I have to say that 2005 has been an eventful year. We have seen an increase in our membership with record attendances at our seminars. The 2005 National Conference that we hosted was an immense success, thanks to our Vice-President Mr Kevin Siu and his dedicated committee. This year has also seen the establishment of a new ACMAV Library Trust, the ACMAV Foundation that now has tax-exemption status from the ATO, thanks to the hard work of past President Dr Benny Foo. This means that donations to the ACMAV from now on may be tax-deductible.

We have also seen the role of the Association changed from being an inward-looking to an outward-looking one. Thanks to the initial hard work of Dr Benny Foo and the perseverance and connections of Dr Theong Low, we have seen the Association make a difference in the Australian and International community with our efforts that changed the life of a Vietnamese child who underwent surgery required for encephalocele. This work has not gone unnoticed as evident by the multiple newspaper articles featuring the efforts of the ACMAV, bringing to fruition the successful operation, with the help of surgeons at the Royal Child's Hospital. Since then, the Association has made links with other charity organizations to raise money for further non-profit medical work. We are now planning to bring in three more Vietnamese children for further sponsored surgery. Let me say that I for one am honored to be part of an Association that is at last maturing, not just as a "club for doctors" but an organization that seeks to better the lives of those around us who are less fortunate.

We have seen the ACMAV website moved to www.acmav.org and the website has been revamped with a user-friendly format. We have upgraded the computer system and software at ACMAV House. I think we all agree that our President, Associate Professor Frank Thien, together with the current Council and every single contributing member, have together brought our Association to this new and exciting level.

There is a lot more to be done. In the Victorian medical system, things are not as well as it seems; the government continues to make changes to the law to the detriment of both doctors and their patients. We are informed that Bronwyn Pike, the Victorian Health Minister, plans to introduce new laws so that a Government body oversees the registration of all health practitioners; in other words, the Medical Practitioners' Board of Victoria may play a lesser role. Also, the Government plans to use this law to allow non-doctors to access Medicare. It is intended, and this is clear in the preparatory statements made in relation to the new laws, that the role of non-doctors will be expanded so that they will be able to provide services that doctors are trained to do – for example, nurse practitioners will be able to prescribe drugs and order tests which are required for investigation of disease processes in the patient. The Health Minister has also stated that she is considering making trainee doctors in public hospitals pay a fee to the public hospital (that is, to the Government) for specialist training while serving in these institutions. It is imperative that all Association members support our Victorian *AMA to fight these changes that the Government is proposing. Indeed some of these issues, for example the Health Professional Registration Bill will be enacted before the end of this year. We all remember the debacle when provider numbers to graduate Medical Practitioners were restricted 10 years ago unless you served in rural areas, because the Government told us there were too many GPs. The Government now tells us we don't have enough GPs and is trying its best to import more doctors from overseas. As doctors, we must continue to make our voices heard, not to protect ourselves but to protect our patients so that they receive not only the best, but appropriate treatment.

I look forward to 2006 when we can all work together to raise the profile of our Association for the benefit of our community through the unity of our members.

** Editor's note: "Benefits of AMA Membership" is outlined by Dr W. Glasson on page 116 with application forms attached.*

Erwin Loh

Treasurer's Report

The association continues to be strong in financial balance in 2005. There is healthy growth in membership numbers with membership fee remaining unchanged - this must be the best value in town for any professional association.

Pharmaceutical companies continue their support for our medical seminars and annual conferences, thanks to the hard work of all the Committee Members.

2005 also saw the birth of our ACMAV Foundation with transfer of funds from the Library Trust to the Foundation being completed. We are grateful for the foresight and hard work of Dr Benny Foo.

Lawrence Wu

Community Services Report

The Association continues its active role in *Health Promotion in Community* with talks held at the Elderly Citizens Club in Box Hill. The three speakers including Dr Howard Tang, Prof Yean Lim and Prof Joe Tjandra. The topics of Cardiovascular and Gastrointestinal Medicine were interesting talks with simple interpretation of sometimes complicated conditions explained in layman terms. They all achieved the aim of improving general knowledge and public awareness relating to the topics and were well received by the Elderly Citizens.

Dr. Siew-Khin Tang gave a talk on Cervical Cancer and Human Papilloma Virus (HPV) infection to the Victorian Chinese Women's Association. Her talk emphasised the role of HPV vaccine which will be introduced to young women and adolescent females, for the prevention of cancer of the cervix.

Note: Any members interested in continuing this worthwhile health promotion programs are encouraged to contribute their expertise in conducting seminars on topics in their field of expertise.

Lawrence Wu

Tennis Tournament



The 11th Annual ACMAV Tennis Tournament was held on 24th October 2005. The winners were Trevor and Douglas Gin. The runners up were Trevor Lau-Gooley and Theodore Tang. Once again we thank Mayne Health for their generous sponsorship of this tournament.

Trevor Lau-Gooley

ACMA and ACMAV Conference 11th - 13th June 2005

Venue : Park Hyatt Hotel

The 2005 ACMAV conference was the highlight of the ACMAV Calendar year. Under the leadership of conference Convenor, Kevin Siu, over 15 months of planning and hard work was put into this one event. Not only was this event the National meeting of Australian Chinese Medical Associations, this was also the 20th Anniversary of ACMAV.

Delegates from 5 Australian states (QLD, VIC, SA, NSW and WA) and New Zealand met at the beautiful Park Hyatt Hotel. The well attended social program consisted mainly of eating at some of Melbourne's finest establishments. There was afternoon tea at the famous Windsor Hotel and delicious Yum Cha at Shark Fin's House.

The lecture program combined the best of science (advances in medicine and the latest in neurosurgery) with the best of life (inspirational presentations of overseas aid projects and art).

The most enjoyable section of the 2005 ACMAV conference, however, was the conference dinner. While the "Three Waiters" initially entertained the diners with their comedy and antics, there was genuine wonder and delight as all 3 broke out in song with their strong and vibrant voices. Kevin Siu had been planning the "Three Waiters" as a surprise for ACMAV for months – and all on the conference committee who knew of their secret identities had been sworn to secrecy. The best surprise of all was when Theong Ho Low (organiser of Project Vietnam) lifted little Tuong Van on his shoulders and showed us this smiling happy child whose face (and life) has been transformed through radical facio-maxillary reconstructive surgery which is unavailable back home in Vietnam. I have never been so proud to be a member of ACMAV.

Mee Yoke Ling

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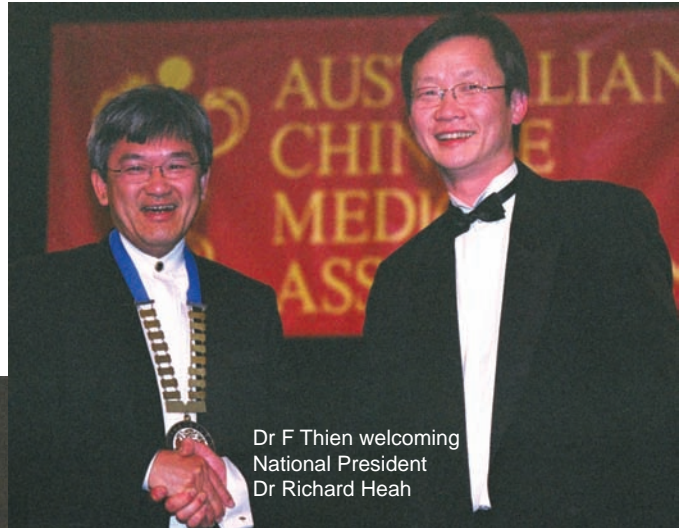
Australian Chinese Medical Association, Victoria
ACCMA and ACMAV Conference 11th - 13th June 2005
Grand Ballroom, Park Hyatt Hotel
 1 Parliament Square, Melbourne 3000

PROGRAMME

| Saturday 11th June 2005 | | 3.00 pm | AFTERNOON TEA |
|--|---|--|--|
| 2.30 pm | Registration | SESSION 3 | Medical Pot Pourri II Chairperson: Tom Tsiang |
| 2.30 – 4.30pm | Afternoon Tea Grand Ballroom, Windsor Hotel Spring St, Melbourne | | |
| Evening | At Leisure | | |
| 6.30 pm | ACCMA Committee Meeting | 3.30 pm | Update on Bowel Cancer Screening Dr Howard Tang |
| Sunday 12th June 2005, Ballroom, Park Hyatt Hotel | | 4.00 pm | Interventional Radiology - Endovascular Management of Intracranial Aneurysms A/Prof Peter Mitchell |
| 9.00 am | Registration Morning Tea/Coffee | 4.30 pm | Aneurysm Clipping Mr John Laidlaw |
| 9.50 am | Welcome Conference Convener | 5.00 pm | Close |
| SESSION 1 | Advances in Medicine Chairperson: Dr Mee Yoke Ling | 7.00 pm | CONFERENCE DINNER Ballroom, Park Hyatt Hotel (Dress code: Lounge Suit) |
| 10.00 am | Update in Cardiology Dr Yew Mun Cheong | Monday 13th June 2005 Shark Fin House, 131 Little Bourke St, Melbourne | |
| 10.40 am | Artificial Disc Replacement Mr Graeme Brazenor | SESSION 4 | Kaleidoscope Chairperson: Dr Lawrence Wu |
| 11.20 am | Common Eye Conditions in Chinese Patients Dr Kevin Foo | 9.00 pm | Light Morning Snack |
| 12.00 pm | LUNCH | 9.30 pm | Hospital by the River, Bangladesh Dr Judith Goh |
| SESSION 2 | Medical Pot Pourri I Chairperson: Dr David Chong | 10.00 am | Art and Heart Prof Yean L Lim |
| 1.00 pm | Insulin Management in Type 2 Diabetics Dr Sylvia Lim-Tio | 10.30 am | The Art and Science of Youthfulness Dr C K Foo |
| 1.40 pm | Acute Coronary Syndrome Prof. Yean L Lim | 11.00 am | YUM CHA LUNCH at Shark Fin House |
| 2.20 pm | Psoriasis Dr Adrian Mar | 1.00 pm | Close |



Dr Kelvin Siu covenor



Dr F Thien welcoming National President Dr Richard Heah



One of the "tenors"



Another "tenor"



Cutting the 20th ACMAV Anniversary Cake



Interstate participants



Speaker Dr Yew Mun Cheong



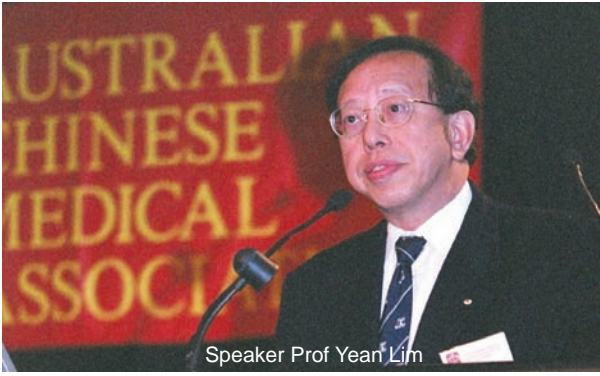
Dr K Tang and speaker Mr Brazenor with guest and registrant



Registrants



**Australian Chinese Medical Association
ACCMA and ACMAV Conference
11th - 13th June 2005**



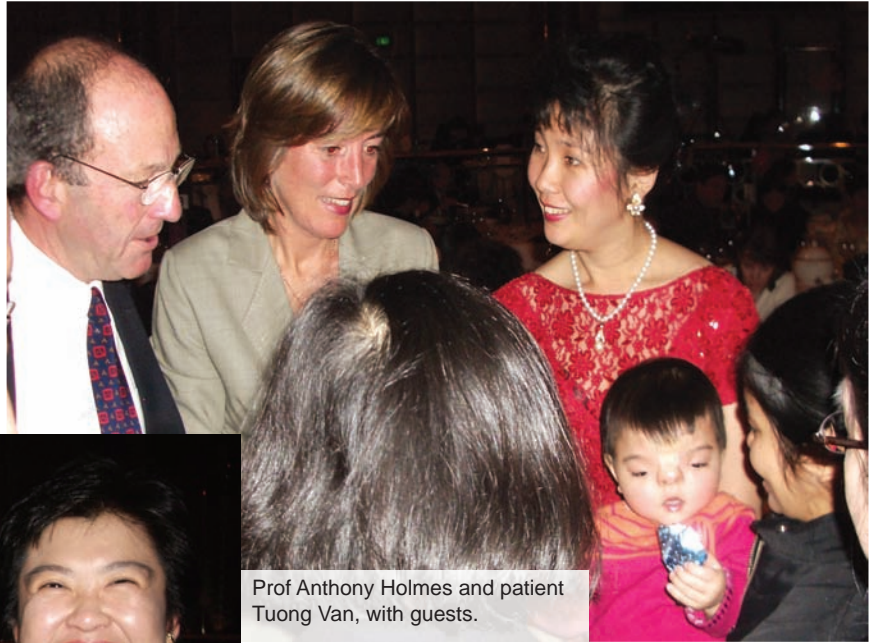
Speaker Prof Yeap Lim



Registrants.



Speaker Dr A. Mar and registrants



Prof Anthony Holmes and patient Tuong Van, with guests.



Organising committee



Registrants



Dr Theong Low with Tuong Van and her mother

**Dinner at the Grand Ballroom
Park Hyatt Hotel, Melbourne**

AUSTRALIAN CHINESE MEDICAL ASSOCIATION (VICTORIA) INC.

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Distinguished Personality

Mr Boon-Hung Hong:

Sifu, Surgeon and champion of Chinese culture



Just who is Mr Hong? Before coming to work for him at the Northern Hospital, I heard stories about him by his previous registrars, extolling his operative speed and efficiency (he is the surgeon who puts the most cases on his list in a session); how fast he talks (this leaves the Aussies occasionally trying hard to catch on or do what he says, although it was never a problem for me); of his martial arts skills (it is said that he can fell an enemy with a single move!).

In between trying to learn some martial arts, medical Chinese terms and surgery from him, I have had the chance to ask him about his background and past.

He was born in Putien in the Fuchien province in 1946. He attended primary school there and migrated to Borneo in 1958 after his uncle met Mao Tse-Tung to obtain permission for him and his cousins to leave China. His uncle at the time was a very successful businessman in Borneo who needed more assistance to expand and manage the family business.

Hence Mr Hong completed his secondary school education in Sabah. He emerged as the top student in Sabah at Chinese Senior Middle Three level. As a result of this he was offered a scholarship to study medicine in Taiwan and another scholarship to study Engineering at UCLA (Berkeley). However, he decided to come to Melbourne where he spent nine months doing Matriculation at Taylor's College to improve his English.

Mr Hong enrolled in the Faculty of Medicine in 1967 and graduated in 1972. His colleagues included Doris Young, Wilma Beswick and James Best. His command of English was initially poor: he recalls having to write out his answer in order for the examiners to understand him at one of the vivas for the prize in physiology. He was awarded a scholarship and stayed at International House while studying medicine. During the summer holidays, he spent his time laying bluestones in the courtyard; this he regarded as a form of exercise!

He married his wife Geok-Hong Ooi, a girl from Malaysia, whom he met at the old Queen Victoria hospital in 1972. He elicited the help of the Chief Minister of Sabah to ask permission from Gough Whitlam for him to stay on in Australia, as at that time it was difficult for students to stay and work in Australia.

He obtained his surgical fellowship from the Royal Australasian College of Surgeons in 1978 after completing the required training at the Royal Melbourne Hospital, Austin Hospital and Preston and Northcote Community Hospital (PANCH).

In 1980, Mr Hong was offered positions at the Singapore General Hospital and the Queen Elizabeth Hospital in Kota Kinabalu, Sabah.



Using internal force to uplift an opponent

As for martial arts, he would train for an hour before dawn and again in the evening. He is an expert in both Wushu and Tai-Chi. With his knowledge of anatomy, he has been able to correlate the moves from these martial arts with the anatomical structures and pressure points. At times he would explain to us how he could trip an opponent using his tibialis anterior, or paralyse an opponent's median or radial nerves. He began teaching students the art of Tai-Chi here in Melbourne in 1982. Currently he is the master-in-charge of The Integrated Yang Style Tai-Chi Association of Australia (www.iysta.com.au). He is the most senior instructor of this form of Tai-Chi outside Taiwan.

Among his other cultural accolades, Mr Hong was also Foundation Chairman of the Chinese Cultural Society from 1984 to 1990. This society publishes the popular Hansen

(Chinese Voice) magazine and is well known in the Chinese community in Melbourne. He has close contacts with the top echelons of the Chinese consulate staff in Melbourne, and he has been to China many times as a guest of the Chinese government.

Mr Hong has certainly an amazing life and has lived in very interesting places. He came from a village in China, moved to Borneo, and finally came to Melbourne. Here he and his wife have raised their four children: Andrew, Siew-Lee (both successful dentists) and twins Matthew and Michael who are currently medical students at the University of Melbourne. The Hong's, it appears, will be around for a long time in the medical circles of Melbourne!

Lean-Peng (LP) Cheah



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*Distinguished Personality***Shereen Oon - Top graduate in Medicine 2005**

Interview by Jun Yang



The stereotypical “top student” is one who is all-knowing, achievement focused, time-pressured and possibly a little arrogant. Shereen Oon is the top graduate from Melbourne University’s medical school and is far from that stereotype. In fact, in our one hour interview, she barely touched on her “top seed achievement” – always unpretentious, affable and humble.

Shereen was born in Melbourne, with a Malaysian Chinese background. She attended Caulfield Grammar School before being awarded a full scholarship to Presbyterian Ladies College. Obviously her academic excellence started young, alongside her other talents as a member of her school choir, a pianist (gaining her AMusA diploma in Year 10) and a badminton player!

There are no graduate of Medicine in her family, so Shereen faced the tough decision of choosing between being a doctor or an actuary at Melbourne University. She enjoys the mathematical side of an actuary, but chose the compassion and humane aspects of medicine, much to the good fortune of the medical community.

Academic prowess remained one of Shereen’s strengths throughout six years of medical school. She was awarded an Anti-Cancer Council Vacation Scholarship in her third year for research on “osteosarcoma” in the department of Orthopaedics at St Vincent’s Hospital, and as an undergraduate, was included in the Dean’s honours list every single year. It is therefore not surprising that she graduated in 2004 with first class honours and conveniently took with her the prestigious Stephen Rosen Award (bestowed by St Vincent’s Hospital and Geelong Hospital Clinical School for excellence in clinical medicine) along with the Faculty Prize for highest aggregate score in the final year. Despite these achievements, Shereen is exceptionally modest and attributes it all to being “slow and steady”. So there is some truth to the “Tortoise and Hare Race” tale!

Shereen is currently an intern at St Vincent’s Hospital and has enjoyed her internship rotations so much that every registrar she has worked with has become her role model! I am certain she is also the dream intern, to her mentors. Not infrequently she continues a long day’s work with “tidying things up”; this strong work ethic and sense of responsibility makes her an asset in every department she has served and an angel to each patient she has cared for.

In terms of her career future, Shereen has her eyes set on anaesthetics or physician’s training. She admits to enjoying giving needles! She also appreciates the controlled and sterile environment of the operating theatre, and the opportunity to speak to patients at pre- and post-operative periods. Her medical science degree thesis with the Department of Anaesthetics in 2002 (titled “Pulse transmit time differences as a pre-operative predictor of the nonrecurrent laryngeal nerve”) should definitely put her in good standing, for a career in Anaesthetics.

Had she been given enough time off for a second career, she would have become a cricket commentator! Quite an unusual career option for a female, especially for one of Asian background. Shereen loves to watch the game and could name every single member in each team. I wondered why cricket was her favourite of all sports – why not swimming, gymnastics or badminton? Her answer made it all clear (and even tempted a “non-sport-spectator” like myself to watch a game) – “cricket is an intelligent game and requires a lot of planning and skill”. Could I have expected a less sensible answer?

If not for time constraints, we could have continued chatting about her love for shopping, reading and card playing. She seemed so normal and down to earth, despite being obviously gifted. I wish her every success in her future endeavours and welcome her to ACMAV.

Victorian Tort Law Reforms

- How does it affect Victorian doctors?

Introduction

Much has been written in the last few years about the so called “medical indemnity crisis”. This is actually part of a broader “insurance crisis”. The genesis of the problem has been attributed to the collapse of HIH Insurance, UMP medical defence organisation, the events of September 11, 2001, the general economic downturn in the world economy with resultant investment losses by insurance companies, as well as to a perceived skyrocketing in liability claims.

Whatever the origins of the “crisis”, pressure grew on governments Australia-wide, and indeed world-wide, to solve the problem of the availability and affordability of basic liability insurance cover.

In 2002, the Insurance Issues Working Group of Heads of Treasuries commissioned a report, chaired by the Honourable David Ipp, into tort law reform. This report, entitled “Review of the Law of Negligence” was published in October 2002 and contained over 60 recommendations for tort reform. In 2002 and 2003, the Victorian government, along with other State governments, legislated many of the recommended reforms into the statute books.

We provide a brief summary of the Victorian tort law reforms and its possible impact on Victorian doctors.

First Stage of Reforms

The reforms introduced by the Bracks government in 2002 were stated as aiming at making public liability more available and affordable. The government introduced the Wrongs & Other Acts (Public Liability Insurance Reform Act 2002), together with other associated pieces of legislation, aimed at particular areas of concern in the area of civil liability.

In particular, the government introduced the Volunteer Protection Bill with the aim of protecting volunteers from civil liability for damages. Amendments to legislation were also made to ensure that doctors who gave assistance at the scene of an accident or emergency, so called “good Sa-



Erwin Loh
Medico-Legal Consultant

maritans”, have certain protection from liability. Whether this has an impact on the “good Samaritan” cover offered by medical defence organisations remains to be seen.

Statutory amendments also provided that the giving of an apology, or a waiver of fees otherwise payable, would not, by itself, amount to an admission of liability in regard to a potentially compensable event. Good communication with patients is essential and an appropriate explanation and apology when something goes wrong will go a long way in averting litigation. This change offers protection to doctors when they do offer such an apology. Of course doctors should ensure that, when proffering an apology, they do not otherwise specifically admit any legal liability.

Second Stage of Reforms

The 2002 election, in which the Bracks government won an historic majority in both Houses, afforded it a unique opportunity to introduce further, more far reaching reforms into civil liability.

In May 2003, the Premier announced a legislative package of further insurance reforms. The most significant changes introduced by the Bracks government in the Wrongs & Limitation of Actions Acts (Insurance Reform Act 2003), passed in June 2003, were the introduction of general damages thresholds, the reduction of limitation periods and the introduction of proportionate liability for property damage and economic loss claims. There was a cap on general damages for personal injury awards to a maximum of \$371,380 indexed to CPI and a cap on compensation for loss of earnings awards of three times average weekly earnings. These changes significantly reduced the amount of damages that can be awarded by courts to patients in catastrophic medical negligence cases.

Limitation of actions legislation restricts the time in which a patient can bring legal proceedings where the essence of the complaint is that the doctor has negligently caused physical injury. If a proceeding is not brought within the limitation period it is said to be “statute-barred”, which means that the injured patient cannot enforce their legal claim. Until recently, the general period in Victoria was 6 years. As at 21 May 2003, the limitation period for personal injury actions was changed for adults to 3 years from

the date of discoverability of the right to bring a claim; for minors (and other patients under a “legal disability”), the period is six years from the date of such discoverability. The government also introduced a “long-stop” limitation period of 12 years, meaning that a claim will be statute barred 12 years after the event causing the injury (even if the injury has not been discovered within that 12 year period). This offers significant protection for doctors when it comes to patients bringing up old claims of negligence. Previously a minor potentially had 6 years after turning 18 to bring such a claim, meaning that a doctor involved in a childbirth incident could have been sued up to 24 years after the event.

Nevertheless, it must be noted that despite these changes the Court retains an overall discretion to extend the limitation period where it is in the interests of justice to do so. In considering whether to extend the period, the Court must have regard to a number of factors, including the length of and reasons for the delay; likely prejudice to the doctor; the nature and extent of the patient’s loss; the nature of the doctor’s conduct; and steps taken by the patient to obtain appropriate advice.

Due to these changes doctors would be correct in expecting their medical indemnity premiums to drop. However, at the same time as these Victorian reforms, the Federal Government was also busy making its own changes. The collapse in 2002 of Australia’s biggest medical indemnity insurer, UMP, was considered to be evidence of the dangers of discretionary cover by the Commonwealth Government. This led to Commonwealth legislation requiring medical defence organisations to operate as insurance companies which took effect on 1 July 2003. Even though premiums for medical indemnity insurance have dropped, these changes to the structure of medical defence organisations mean that the drop is not proportional to the drop in actual claims.

Third Stage of Reforms

In late 2003 the Bracks government passed the Wrongs and other Acts (Laws of Negligence) Act 2003 (‘the Act’), the majority of which commenced operation on 3 December 2003. The final wave of tort reform essentially aimed to create certainty in relation to the law of negligence by codifying legal principles such as foreseeability, causation and voluntary assumption of risk, clarify the tortious liability of public authorities, place limitations on recovery of damages for mental harm and introduce a new test for professional negligence.

The Government contended that the reforms introduced had no impact on common law, except to the extent that the provisions in the Act specifically restate or modify the common law. However, as set out below, this is not strictly correct.

Impact on the Law of Medical Negligence

The Act defines negligence as the “failure to exercise reasonable care”. A duty arises where the risk was foreseeable, the risk was “not insignificant” and a reasonable patient would have taken precautions.

The Act also requires doctors who have a duty to provide a warning or information, to take reasonable care in providing the warning or giving the information.

The common law test previously used the term “not far fetched or fanciful”. This has now been replaced with “not insignificant”. Not insignificant risks are defined as all risks other than insignificant risks and include but are not limited to significant risks.

Suggestions so far appear to indicate that a risk that is not insignificant is a risk that is more plausible in materialising than a far fetched or fanciful risk. The result is that it is arguably more difficult for a patient to make out his case.

Where there is an obvious risk, the Act creates a presumption, where the defence of voluntary assumption of risk is pleaded (such as sporting injuries), that the patient is aware of that obvious risk. The presumption may be rebutted if the patient can prove that he or she was unaware of the risk. The important thing to note for doctors is that this presumption does not apply in relation to damages claimed arising out of professional or health services, or in respect of risk associated with work done by one patient for another. In other words, a doctor cannot presume that a patient is aware of an obvious risk involved in medical treatment.

An “obvious risk” is defined as a risk that is “patent or a matter of common knowledge”, and may be obvious even though it has a low probability of occurring. Skiing may be a good example of this, as although the risk of death is low, it is nevertheless obvious because it may be described as a matter of common knowledge.

The High Court of Australia in *Rogers v Whitaker* at paragraph 16 said:

“The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable patient in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware if a particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to their therapeutic privilege.”

The Act codifies the common law in relation to inherent risks by not making the doctor liable if a patient took on that inherent risk. An “inherent risk” is defined as “something that cannot be avoided by the exercise of reasonable care”.

In a claim for damages for personal injury, the patient will have the responsibility of establishing any fact relevant to proving to the Court that the doctor was responsible for the damage. Where it is not possible to establish that the doctor was responsible for the damage, the Court may consider whether it is appropriate, in any event, to find the doctor negligent.

Where relevant, the Court can make a determination on what the injured patient would have done but for the negligent actions under the circumstances. This is a subjective consideration of what actually happened to the injured patient, rather than an objective consideration of what a hypothetical reasonable patient would have done under the circumstances. The test thereby gives greater scope for the injured party to ask the Court to consider “what might have been”.

As a result of the amendments, a Court may now find the patient 100 percent contributorily negligent, thereby completely defeating the original damages claim. Previously the common law position did not permit a finding of 100 percent contributory negligence. Therefore, if there is evidence to show that the patient was negligent, for example in not attending follow-up appointments or following medical instructions, the Court may find the patient to be negligent rather than the doctor.

The codification of liability of professionals sees changes from the common law. The common law test to determine the standard of care of professionals and whether there is a breach of duty has been modified by the Act.

The common law test on the question of peer opinion in Australia was embodied in the so called “Bolam rule”. The rule derives from a famous statement by McNair J in the English case of *Bolam v Friern Hospital Management Committee* :

“a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... merely because there is a body of opinion that would take a contrary view.”

Under the rule the doctor will be held to have exercised reasonable care if what was done was in accordance with ‘a responsible body of medical opinion’.

In 1992 in *Rogers v Whitaker*, the High Court of Australia unanimously rejected the application of the Bolam principle in Australia. That case involved a rare case of sympathetic ophthalmia, where the claimant convinced the Court that, had she been warned by the surgeon of the (extremely low) possibility of going blind in her good eye, she would not have agreed to undergo the eye surgery. Whilst the decision is authority for cases of this kind, there are passages in the judgement in which the High Court indicated that the Bolam principle is also not applicable to negligence in diagnosis or treatment in Australia.

However, in *Naxakis v Western General Hospital*, a case of negligent treatment, three members of the High Court of Australia – Justices Gaudron, McHugh and Kirby – all treated the principle laid down in *Rogers v Whitaker* as being applicable to negligence in treatment.

Nevertheless, a different interpretation of the law would appear to have been made by the Victorian Court of Appeal in *Howarth v Adey*. In that decision President Winneke (Justices Brooking and Callaway agreeing on this point) said: “In the case of negligent treatment and medical management, the principles explained and defined in the Bolam case apply”.

As recommended by the Ipp Report, a “peer professional opinion” test has been reintroduced by the Victorian tort reforms. Under this test, a doctor will not be considered to have acted negligently if he or she acted in a way that, at the time the service was provided, was widely accepted as competent professional practice in Australia by a significant number of respected professionals in the field.

The section differs slightly from the traditional Bolam principle. The requirement that the opinion be “widely held” is designed to prevent reliance being placed on localised practices that develop in isolation from the main stream of professional activity. The requirement of a “significant number” is designed to filter out idiosyncratic opinions. The requirement of “respected practitioners” is designed to ensure that the opinion deserves to be treated as soundly based. However, it does appear to override *Rogers v Whitaker*.

Effects of the Victorian Reforms

The most dramatic medium term effect of the Australia-wide tort reforms is a significant drop in the number of personal injury claims being brought. A recent report revealed that figures released by the Productivity Commission have shown that civil claims fell nationally by more than 43,000 in the three years since governments introduced the reforms.

However, a recent report suggests that the number of malpractice claims against doctors could continue to rise despite changes to these law reforms. A review of lawsuits in Australia between 1995 and 2004 found the number of legal claims against doctors from 12 speciality groups increased an average 20 per cent. According to the report, released by the Medical Indemnity Industry Association of Australia, the increase was in part due to tort law reform which reduced the time patients had to sue doctors, sparking a rush of claims between 2000 and 2002.

The full impact of the Victorian tort law reforms on the practice of medicine has yet to be felt. There have not been many major medical negligence cases since the reforms so whether there have been any practical changes to the common law of negligence by the new Victorian legislation remains to be seen.

Government Restrictions on Surgical Training a Trainee's Perspective

The State and Federal governments have continued to deny their role and responsibility in the training of young Australian surgeons.

Firstly, both the governments need to act upon the problems plaguing the country's health system including the shortage of surgeons in Australia. The media often highlights lengthy and increasing operating waiting times in the public health system. Older surgeons in regional Australia are retiring. Queensland Health cut corners and imported Dr Death without the involvement of Royal Australasian College of Surgeons (RACS). According to Professor Bob Birrell, an independent demographer from Monash University, demand for surgical procedures will increase by at least 50% by 2021. If ignored, the surgeon shortage will only worsen. If our public hospital system is not coping with the current workload, how is it going to cope with this increasing demand? Surely our governments realize that they need to increase the funding and resources available to our health care system to meet this demand?

Secondly, both governments play a big role in determining the number of surgeons being trained in our country. Recently there has been a significant amount of media attention on surgical training. In 2003, the Australian Competition and Consumer Commission (ACCC) authorized the RACS to continue foreseeing the training of surgeons in Australia. Despite the approval of ACCC, ill-informed State and Federal politicians continued to make ridiculous and unfounded allegations that surgeons were operating a closed-shop fraternity and restricting the numbers of surgical trainees. State health ministers threatened "radical" action including taking the RACS back to ACCC over the number of recruited surgical trainees, a move welcomed by RACS councilor Professor Guy Maddern. Ms Bronwyn Pike, Victorian Health Minister has tried scare-mongering techniques. "There are informal conversations occurring in many places about alternative providers of surgical training," she said.

The fact is that the public health system, managed by both the governments, is currently under-resourced to provide

adequate surgical experience for an increased number of surgical trainees. The NSW Government reduced the amount of operating time available to surgeons in public hospitals by cancelling or shortening surgery lists, minimizing training opportunities. Outpatient clinics in both NSW and Victorian public hospitals have been closed. Poor working conditions have encouraged medical specialists to leave the largest Tasmanian hospital, significantly reducing operating sessions. State and Federal governments do not seem to understand the process of surgical training. According to Professor Maddern, further increases in trainee numbers could only be achieved currently by decreasing the quality of training. "We are not going to compromise our standards just because the State government is not providing adequate resources," he told the media late last year.

The RACS significantly increased the number of basic surgical trainees, but the governments did not respond by reciprocal increases in funding increased numbers of advanced surgical trainee posts. As a result, a bottleneck is created where surgical trainees are stranded halfway through their training program and are unable to continue. They have to wait for years and compete with fellow colleagues to continue their training. Some of these trainees become disillusioned and eventually drop out, either voluntarily or otherwise.

Thirdly, as a basic surgical trainee myself, most of us are angered and frustrated by the governments' attitude and lack of understanding towards surgical training. We do not want to compromise the quality of our surgical training. We do not want to worry about this bottleneck of surgical trainees being exacerbated by government policies. We want to train, operate and treat patients. We want to encourage younger peers to join our specialty. We want to maintain our reputation as having one of the best surgical training programs in the world.

I write this article aiming to raise awareness and hopefully drawing us a small step closer towards an improved surgical training program.

Cheng Hean Lo
Surgical Trainee

What is PBL?

Problem based learning (PBL) is an approach to learning in which students tackle problems in small groups with a group facilitator. PBL has spread across medical schools around the world and is included in the core curriculum of Melbourne and Monash University Medicine Schools. There has been much concern by doctors who graduated from western medical schools questioning the benefit of PBL.

The History

Problems are used as the starting point to engage th students in PBL. Using a problem based approach in education is not new. Dewey, an educational theorist, recommended in the early 1900's that students should be presented with real life problems in order to discover the information required to solve them (Spencer & Jordan, 1999). In the 1960's, McMaster Medical School in Canada

in 1974. The PBL approach has now spread world wide.

The Process

The typical PBL tutorial consists of a small group of students and a tutor who facilitates the session (Figure 1). describes the steps of PBL, with an example alongside. The group is presented with a problem which acts as a trigger to stimulate group discussion. After the learning objectives are defined, the group breaks up and students study privately. Then they return as a group to discuss and refine their acquired knowledge.

Typically a group stays together for 6 months or a year. Across Australia (and the world), PBL is used in the medical curriculum in a variety of ways. PBL may be used as the mainstay of the curriculum (this is often called a `PBL curriculum') or the PBL approach may be used for individual courses / parts within the medical school course (Wood 2003).

Fig 1.

| PBL process (adapted from Woodward 1996, Bligh 1997) | Example of a PBL case (and hypothetical group of medical students) |
|--|--|
| 1) A problem is presented to the group. Unfamiliar terms are clarified. | 1) "Mrs Edith Po, a 75 yo retired school principal, presents with shaking of her left arm. It has been worsening for the past 4 months. It occurred mainly at rest and could be dampened by movement. Edith realised that `something had to be done' when a friend asked her if she was nervous and why her hand was shaking so much." |
| 2) As a group, the students - discuss the problem -generate explanations ("brainstorming") on the basis of prior knowledge - identify the areas which they lack information to understand the problem. - formulate a strategy of enquiry and define "learning objectives". | 2) The students brainstorm the causes of Mrs Po's shaking. Student A. has heard of Parkinson's Disease, Student B thinks this could be a stroke, Student C suggests - "nerves". They decide that they need to revise neuro-anatomy (with regards to motor pathways) and to investigate the causes of tremor. |
| 3) The group then breaks up and the students study privately. They engage in a variety of independent learning activities which help them to explore the issues involved in obtaining a deeper understanding of the problem. | 3) Using textbooks, the internet, course notes and other available sources - the students research their learning objectives. Some students decide to visit the neurology ward and see patients with a similar presentation. |

pioneered the first completely problem-based medical curriculum. Maastricht soon followed



Mee Yoke Ling
General Practitioner

PBL in Practice

Implementing PBL is costly - in terms of time, money and logistics (Albanese & Mitchell,1993). Just for a start - there are the resource costs of locating rooms for small groups,

faculty training, and paying tutors to be facilitators. However, the experience from Harvard University medical school has been such that once the initial start-up period is over, the PBL programme costs about the same as the conventional one to run (Bligh & Wilkinson, 1997).

“Is it worth it?”

From the point of view of adult learning theory, PBL makes sense. The students are active participants of the learning process. PBL is designed so that students can take responsibility for their own learning (self-direction) and develop adult learning skills (Kaufman et al., 2000). Research has consistently shown that students and staff enjoy the PBL process.

But - “does PBL work?”

At the end of course assessments, PBL produces results comparable to conventional teaching methods. When comparing medical students who have graduated from a conventional curriculum versus medical students who have graduated from a PBL curriculum, the evidence shows little or no difference in students' acquired knowledge between the two groups (Albanese 2000, Colliver 2000, Norman and Schmidt 2000). Proponents of this teaching method argue that PBL has generic benefits that are not easy to measure by end of course MCQ exams. These generic benefits include the development of teamwork and cooperation skills, presentation skills and respect for colleagues' views (Wood 2003).

In Conclusion

PBL is an approach to learning in which students tackle problems in small groups with a group facilitator. The costs and benefits of PBL have been discussed.

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*Congratulations to Adrian & Jun
on their marriage, November 2005*

ACMAV Calender of Events 2006

| | Date/Venue | Topic / Speaker(s) | Sponsor(s) / Venue |
|---|-------------------|---------------------------|--------------------------------------|
| 1 | 12 February | Chinese New Year Yum Cha | Jackie's Kitchen, Doncaster |
| 2 | 8 March | STD and androgen testing | Dorevitch as Sponsor, Sharkfin House |
| 3 | 3 May | AGM | Taipan restaurant |
| 4 | June | Seminar to be announced | To be announced |
| 5 | 10 to 12 June | ACCMA National Conference | South Australia |
| 6 | 13 August | ACMAV Annual Conference | Novotel Glen Waverly |
| 7 | October | Seminar to be announced | To be announced |
| 8 | December | Seminar to be announced | To be announced |



Medical

Prostate Cancer – Questions and Answers

Chi Can Huynh, Prem Rashid

What do we know about the risks of prostate cancer in Australia?

According to statistics, about 10,500 men are diagnosed with prostate cancer each year making it the most commonly diagnosed cancer in males. The rate of diagnosis of prostate cancer increases with age.

If you are in your 50's, you have a one in eighty (1.2%) chance of being diagnosed with prostate cancer in the next ten years. If you are in your 70's, you have a one in twelve (8.3%) chance of being diagnosed with prostate cancer in the next ten years .

All men diagnosed with prostate cancer run the risk of dying from it but that risk varies with age and on their health status.

Who are susceptible?^{ii iii iv v vi}

We know for certain that age and family history are the most important risk factors for prostate cancer. There is no modal peak incidence for prostate cancer and autopsy studies show that 80% of men over 80 years of age have this disease. Single first-degree relatives with prostate cancer will have a 2-3 fold increased risk. Each successive extra first-degree relative will basically double the risk.

| No. of 1 st Degree Relatives with Prostate Cancer | Relative Risk |
|--|---------------|
| 1 member | 2-3 |
| 2 members | 4-6 |
| 3 members | 10-11 |



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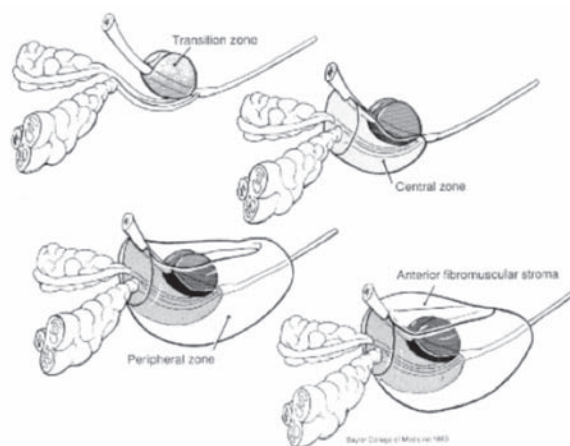
Diet seems to be an important player in the aetiology of prostate cancer. High dietary fat especially from red meat has been linked with an increased risk of developing prostate cancer. Selenium, soy products, vitamin E and lycopene from tomato sauces have been shown to reduce the risk of prostate cancer.

There are some other suggested links such as those exposed to cadmium and working in the nuclear power industry. Sexual behaviour is an uncertain risk factor. Vasectomy is not related to prostate cancer risk.

What are the prostate zones?

The zonal anatomy of the prostate is particularly important. The three zones are the:

- Peripheral Zone (65%)
- Central Zone (25%)
- Transitional Zone (10%)



Zonal anatomy of the prostate as described by J.E.McNeal(Am J Surg Pathol 1988;12:619-633. The transition zone surrounds the urethra proximal to the ejaculatory ducts. The central zone surrounds the ejaculatory ducts and projects under the bladder base. The peripheral zone constitutes the bulk of the apical, posterior, and lateral aspects of the prostate. The anterior fibromuscular stroma extends from the bladder neck to the striated urethral sphincter.

Adapted from Campbell's Urology 8th Ed (2003)

Most benign prostatic enlargement/hypertrophy (BPE/BPH) occurs in the transitional zone. This is why rectal examination of the prostate does not correlate well with the degree of urinary obstruction. 70% of prostate cancers occur in the peripheral zone. This fact lends itself well in its detection via a digital rectal examination (DRE).

So how do we test for prostate cancer?

It is important to understand that when a patient presents with lower urinary tract symptoms (LUTS), that this is not confused with it being a symptom of prostate cancer. As explained, most prostate cancers arise from the peripheral zone, whilst BPH arises from the transitional zone. Early prostate cancer in itself does not usually produce urinary symptoms. *The practical issue remains that early prostate cancer and symptomatic BPH may co-exist.*

The combination of a PSA blood test and a DRE is essential in the risk assessment of prostate cancer. A PSA test without a DRE is not the preferred way to assess a man for prostate cancer. A normal prostate will feel firm and symmetrical (two lobes) with a subtle groove between the lobes. An abnormal feeling prostate could be asymmetrical and may have focal nodularity or induration. *A man with an abnormal feeling prostate could consider a PSA test and referral to a urologist for an opinion.*

What is the PSA test?

PSA stands for Prostate Specific Antigen. It is *prostate specific*, not *prostate cancer specific*. It is a glycoprotein responsible for liquefying semen. Most remains in the prostatic ducts with only a proportion absorbed into the bloodstream where it is bound by two serum proteins. Thus there are other causes that will produce a rise in PSA.

| Differential Diagnosis of a Raised PSA |
|---|
| Prostate Cancer |
| Benign Prostatic Hypertrophy |
| Urinary Tract Infection (Cystitis, Prostatitis, Epididymo-orchitis) |
| Professional Bicycle Riding |
| Instrumentation of the Lower Urinary Tract |
| Recent Ejaculation |

| PSA Age-Specific Ranges | Ng/MI |
|-------------------------|-------|
| <49 | <2.5 |
| 50-59 | <3.5 |
| 60-69 | <4.5 |
| >70 | <6.5 |

There are other ways of using the PSA test to increase its usefulness. They include using age specific ranges, PSA density which is looking at its value in relation to prostate size and the proportion of free and bound PSA. *The most useful is the PSA velocity which is its rate of change, anything >0.75ng/ml per year is significant.*

Despite PSA's shortfalls, it is the best marker we currently have.

Who should be tested?

The Urological Society of Australasia recommends annual testing, after appropriate discussion, of men aged between 50 and 70 with at least 10 years of life expectancy^{viii}. Those over 40 with a family history should also be tested. Appropriate counselling regarding risks and benefits of testing should occur before testing.

How is a prostate biopsy performed?

Most prostate biopsies will be performed in an outpatient setting with a local anaesthetic. Some may be done in a hospital setting usually for the purpose of a short sedating anaesthetic. Most urologists will have a regimen of oral antibiotics and a suppository on the day of the procedure. The patient will lie on their side and under ultrasound guidance, usually 12 standard needle biopsies will be performed. If there are palpable abnormalities, these may be specifically biopsied using a finger-guided technique.

The common complications include:

1. Rectal Bleeding
2. Haematuria
3. Haemospermia
4. Prostatitis, very occasionally septicaemia.
5. Urinary retention

Most bleeding will settle. Prostatitis may warrant admission into hospital for intravenous antibiotics. Septicaemia

is managed in hospital with intravenous antibiotics and supportive measures as required.

What is a Gleason Score? ix

When a needle biopsy is performed and prostate cancer is seen histologically, a Gleason score is assigned to grade the disease. It is a histological grade based on the architecture rather than focussing on individual cells.

| Gleason Score | Grade of Disease |
|---------------|---|
| <4 | Well Differentiated Tumour 25% risk of progression in 10 years 4-7% risk of death within 15 years |
| 6-8 | Moderately Differentiated Tumour 50% risk of progression in 10 years |
| 9-10 | Poorly Differentiated Tumour 75% risk of local progression over 10 years 60-80% risk of death within 15 years |

How is prostate cancer staged?

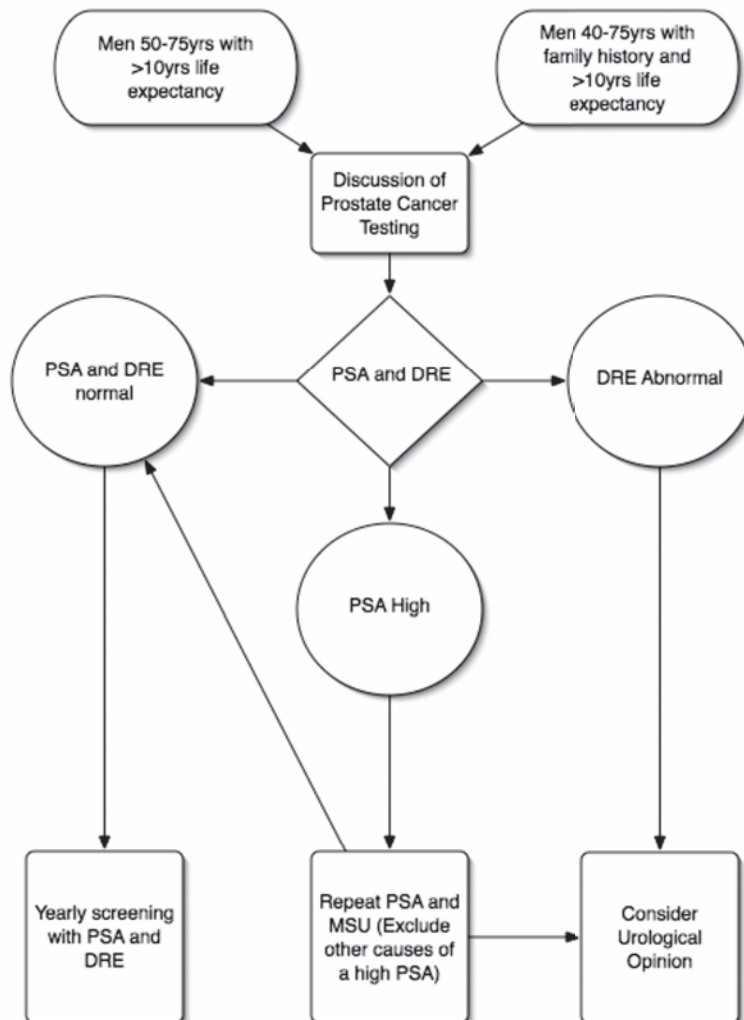
The most current staging system used is the TNM system. The clinical stage is prefixed by a lower case ‘c’ and indicates the stage before any investigations for prostate cancer has occurred. The clinical stage is more often than not underestimated. The pathological stage prefixed by a lowercase ‘p’ is given after a radical prostatectomy when actual histological specimens are obtained. Stage T1-T2 are likely to be localised disease whereas T3-T4 indicate locally advanced disease.

What Treatments are Available?

The management of prostate cancer is wide, varied and controversial. The treatments used should depend on what the patient desires, premorbid state and the extent of disease. Below is a table of the common modalities.

| | |
|---|---|
| Active Surveillance | Otherwise known as ‘watchful waiting’. Usually for men with short life expectancies or low-grade disease. Problematic because of patient anxiety. |
| Surgery | Will offer best chance of cure in someone with organ confined low/moderate grade of disease with good life expectancy. Most commonly this is in the form of an open retropubic radical prostatectomy. Laparoscopic (+/- robotic assisted) and perineal radical prostatectomy offer the same outcomes. Robotic assisted surgery is very expensive both for the patient and the healthcare system. Whether the cost is justified is yet to be determined. Erectile dysfunction and incontinence are potential side effects of radical prostatectomy in all its forms. |
| Radiation Therapy | Seed brachytherapy is a good alternative to surgery in organ confined, low/moderate grade disease. High dose rate rod brachytherapy followed by 5 weeks of external beam radiotherapy is reserved for high-grade aggressive disease. The traditional 7 weeks of external beam radiotherapy alone remains a time tested appropriate way to manage low to high grade, as well as, high volume disease. Advantages of radiation therapy in all its forms are good rates of cure without the need for surgery and its immediate complications. Disadvantages are that psychologically the cancer has not been removed and the potential short and long term effects of radiation including urethritis, prostatitis, cystitis and proctitis. |
| Androgen Deprivation Therapy (ADT) | For those with advanced disease. Treatment can be in the form of surgical or medical orchidectomy. |
| Chemotherapy | For those with androgen independent disease. |
| | |

An Algorithm for Prostate Cancer Testing



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Interpretation of Prostate Cancer Pathology

John Pedersen

The advent of new surgical and radiotherapy techniques has altered the treatment and management of prostatic carcinoma. Serum PSA tests have made it possible to have a relatively good “screening test”. Prostate cancer is now often diagnosed at a treatable stage.

The function of the histopathologist has changed in the last 10 years. Our role has changed from diagnosis to diagnosis and prognosis. This is very important in the management of prostate carcinoma.

The first interaction with the patient is in reading of the transrectal needle biopsies {TRUS biopsies}. Between 6 and 12 different sites of the prostate can be biopsied. We confirm the presence or absence of carcinoma. If malignancy is present, we give a histological grading (Gleason score), the ‘volume’ of cancer in each needle core and the number of needle cores that are positive. This is outlined in Figure 1.

The Gleason score is based on the two most prominent patterns of carcinoma. Carcinoma of the prostate often has many histological patterns. Dr Gleason showed that the prominent patterns can determine the prognosis. In needle biopsies the prominent patterns equate to the highest grades. There are five defined patterns, scored 1 to 5, going from low-grade to high-grade. The score is based on the two most common patterns, i.e. $3+4=7$. It is important to remember that the amount of Gleason pattern 4 and 5 is significant. The convention is that the first number to appear is the greater in amount. So $3+4=7$ is not the same as $4+3=7$. The latter has a worse prognosis as there is more pattern 4 (high-grade) carcinoma.

Scores of 5 and under indicate a slowly growing tumour. These are often seen in TURP specimens. A score of 8 and over indicates a rapidly progressive tumour. As yet we are not very accurate in separating out the good from the bad cancer that have a score of 6 or 7. These intermedi-

ate grade carcinomas are where a considerable amount of research is being done to try and define those carcinomas that do not need early intervention. Occasionally we can identify extra prostatic spread. The clinician will use all of these results along with the serum PSA in a nomogram to identify management options.

New prognostic markers are being described in the research literature every month. As yet none have become universally accepted. But as with hormone receptors and Cerb B2 in breast cancer, prognostic markers can dramatically alter the clinical management.

If the patient undergoes a radical prostatectomy the histopathologist gives several important results which are summarised in this pictorial Synoptic report (Fig 2&3 - these pictures often helps the patient understand his carcinoma). From this information the treating clinician can advise the patient on the probability of recurrence. The important findings include whether the carcinoma is confined to the prostate “organ confined disease”. If the carcinoma has been surgically removed, identification of spread outside the prostatic capsule is also as important as the Gleason score and the tumour volume. Carcinomas of the prostate are often multifocal. These may be separate carcinomas or multiple seedings from one dominant focus. Carcinomas can arise in various anatomical locations of the prostate. The transition zone is the area of prostate adjacent to the prostatic urethra. Carcinomas in this area usually have a low to intermediate Gleason score and have a better prognosis compared those from the posterior lobes. The posterior lobe carcinomas are more likely to show extra prostatic spread into the surrounding soft tissues as they are located close to this area. A more recently recognized carcinoma arises in the central zone, that area of the prostate lying beneath the bladder neck. These appear to again have a slightly worse prognosis in that they are often Gleason score 8 and above and may also involve the bladder neck surgical margin.

John Pedersen

Senior Consultant, Alfred Hospital and TissuPath, Melbourne.

The area of reporting prostatic carcinoma is constantly changing. We currently rely on Gleason score and the PSA reading. However within the next few years these parameters will change.

There is a close working relationship between the histopathologist and the treating clinician. It is important that we understand each other and that the patient's best interests are the main objective. Pathologists are only a phone call away.

Fig 1.





| | | | |
|---|--|--|--|
|  <p>TissuPath Histopathology & Cytogenetics Services</p> | | Pathologists: Dr John Pedersen APP Dr Siew-Khin (Happy) Tang Dr Tim Nottle A/Prof Michael Gonzales Dr Michael Cohen | |
| DOB: | | SEX: M | |
| Specimen: Tissue | | Episode No: | |
| Collection: | | Lab No: | |
| HISTOPATHOLOGY REPORT | | | |
| CLINICAL NOTES: | | | |
| PSA 5.8. DRE soft prostate. | | | |
| MACROSCOPIC: | | | |
| Specimen 1: Right apex, 10 and 2mm. | | | |
| Specimen 2: Left apex, 15mm. 3-1a. | | | |
| Specimen 3: Right mid, 13 and 8mm. | | | |
| Specimen 4: Left mid, 17, 12 and 1mm. 5-1a. | | | |
| Specimen 5: Right base, 10 and 5mm. | | | |
| Specimen 6: Left base, 14 and 13mm. 4-1a. | | | |
| Specimen 7: Right transition zone, 21mm. | | | |
| Specimen 8: Left transition zone, 20mm. 2-1a. | | | |
| Right side blue. MH ver DS | | | |
| MICROSCOPIC: | | | |
| Specimens 1 to 6: | | | |
| The core biopsies are benign. | | | |
| Specimen 7: | | | |
| There is a 6 mm focus of adenocarcinoma, Gleason pattern 3+4=7, the pattern 4 component is 10%. Perineural invasion is identified. | | | |
| Specimen 8: | | | |
| The core biopsy is benign. | | | |
| Slides seen in conjunction with Dr John Pedersen. | | | |
| CONCLUSION: | | | |
| Multiple prostatic needle core biopsies: Prostatic adenocarcinoma; Gleason pattern 3+4=7; with focal perineural invasion; identified in the right transition zone. | | | |
| Reported by : Nottle, Tim Dr | | | |
| Copies of this report have been sent to :- HOSPITAL | | | |
| Date Printed : 02-Feb-2006 2:12 PM | | Page: 1 of 1 | |
|  <p>RCPA The Royal College of Pathologists of Australasia</p> | | Head Office and Central Laboratory 165 Burwood Road, Hawthorn, Victoria 3122 Phone 03 9815 1588 Fax 03 9819 9250 In partnership with Uropath P/L Dr Ronnie Cohen, Director TissuPath Pty Ltd (APA 1038) ABN 65 106 980 429 | |
| | |  | |

Fig 3.



TissuPath
Histopathology & Cytogenetics Services

Pathologists: Dr John Pedersen APP
Dr Siew-Khin (Happy) Tang
Dr Tim Nottle
A/Prof Michael Gonzales
Dr Michael Cohen

DOB: SEX: M

Specimen: Tissue, Volumetric Episode No:


Collection: Lab No:

VOLUMETRIC REPORT

Reported by : Pedersen, John Dr

Pre-op PSA: 5.8

| | Yes/No | mm |
|-----------------------------|--------|----|
| Organ confined | Yes | |
| E.P.E | No | |
| S.V. involvement | No | |
| Margin positive | No | |
| Apex | | |
| Base | | |
| Posterior | | |
| Anterior | | |
| Gleason pattern: 3+4(15%)=7 | | |
| Prostate tumour stage: T2b | | |




Mr

TUMOUR VOLUME = 0.83cc

With a tumour volume of 0.83cc and a 15% Gleason 4, the risk of PSA failure in this patient is 16-30%.
(Based on data from Stamey *et al*, JAMA 1999; 281:1395)


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Date Printed : 02-Feb-2006 2:11 PM Page: 2 of 2



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The Management of Early Stage Prostate Cancer: The Role of Prostate Brachytherapy

Michael Chao

Prostate cancer is a significant public health problem. It is the second leading cause of cancer death among men. The incidence of prostate cancer increases with age and as life expectancy continues to increase every year, it is likely that the number of prostate cancers diagnosed each year will continue to grow and that an increasing proportion of men may die of this disease. Despite these considerations, some will still continue to question the wisdom of prostate cancer screening and the role of early intervention in patients with asymptomatic early stage disease.

Early prostate cancer is defined by AJCC (American Joint Cancer Committee) as clinical stage T1 or T2a-b, or with Prostate Specific Antigen (PSA) reading of < 10 ng/ml and biopsy Gleason score < or =6. Watchful waiting, radiation therapy and surgery represent the three primary forms of treatment for early stage prostate cancer. However, a recently published randomised study demonstrated significant benefit in patients with early stage prostate cancer offered early intervention (1). The survival benefit has continued to increasingly improve with follow up demonstrating the importance of treatment in patients with long life expectancies.

The management of early stage prostate cancer will be reviewed with particular detail regarding the use of prostate brachytherapy (PB). Eradication of the tumour, prevention of incontinence and preservation of erectile function are the goals of all therapies.

Watchful Waiting

Conservative management or watchful waiting obviates the known complications of erectile dysfunction and incontinence associated with treatment. The 10-year disease specific survival in a Surveillance Epidemiology and End Results (SEER) database of over 20,000 patients with pros-

tate cancer managed conservatively was 82% (2). Although the 10-year survival was relatively high in patients with low or intermediate grade cancers, defined as Gleason score of 6 or less, many patients still developed metastases. In fact up to 15% will have developed metastases at 5 years, rising to almost 40% at 10 years. The development of metastases is associated with significant morbidity and usually portends prostate cancer death within 5 years.

The recently published study by Bill-Axelsson et al. comparing radical prostatectomy with watchful waiting in early stage prostate cancer revealed an absolute 5.3% increase in incidence of death due to prostate cancer at 10 years in patients assigned to watchful waiting (1). The difference is expected to increase with longer follow up, demonstrating the value of early intervention in young men as well as older men with life expectancies beyond 10 years. In addition, radical prostatectomy reduced the risk of distant metastases and local progression.

The role of watchful waiting will be limited to older men and those who refuse early intervention.

Radical Prostatectomy

Radical retropubic prostatectomy (RRP) usually takes 2-3 hours to perform with a hospital stay of less than 3 to 5 days. The patient is discharged with a Foley catheter in place, which is removed within 2 weeks postoperatively. Immediate operative complications include blood loss requiring transfusions, the development of deep venous thrombosis and pulmonary embolus, or damage to surrounding structures such as the ureter or rectum. Long term complications include urinary incontinence and impotence. The rate of urinary incontinence and impotence were 8% and 32% respectively in a study reported by a large tertiary institution (3). In patients with early stage disease,

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Radio Oncologist

the PSA relapse free survival exceeded 90% at 10 years and 80% at 15 years (4).

Laparoscopic radical prostatectomy (LRP) is emerging as an alternative to RRP. A recent summary by ASERNIP (Australian Safety and Efficacy Register of New Interventional Procedures) did not show any differences in complication rate between RRP and LRP (5). However blood loss and transfusions were lower for LRP. Long-term data are not yet available, but early follow up suggests no difference in survival.

Radiation Therapy

a. External Beam Radiotherapy

The rapid evolution in technology used in radiation oncology has allowed the precise delivery of radiation to the prostate gland with little exposure to surrounding structures. The use of 3D conformal radiation therapy or IMRT (Intensity Modulated Radiation Therapy) has allowed for dose escalation and reduction in serious bowel and bladder toxicity. Compared to external beam radiotherapy prior to 1990s where moderate doses of 60-66 Gy were delivered, we are now achieving higher doses in the vicinity of 74-78 Gy with modern technology. Despite this, serious late bowel and bladder toxicity has decreased from 3.3% and 7.7% of patients (6), pre 3D conformal radiation therapy or IMRT, to only 2% and 1% of patients with contemporary therapy (personal communication *JARROC*™ database). Usually the major acute complications are mild urinary symptoms (frequency, urgency and dysuria) and mild rectal symptoms (tenesmus, diarrhoea and bleeding). Impotence increases with time secondary to induced arteritis affecting up to 50% of patients (6).

In patients with early stage disease, the PSA relapse free survival now approaches 90% at 10 years using contemporary external beam radiotherapy (7). The recent availability of 3D conformal radiation therapy and IMRT has not allowed adequate follow up for 15 year results. At 10 years, it is no different to results following surgery.

b. Prostate Brachytherapy

PB is currently the best means of delivering high doses of

radiotherapy to the prostate while minimising adverse effect to the surrounding structures. Low dose rate implants involve the use of I^{125} seeds which are permanently implanted into the prostate where they deliver a continuous low level radiation for approximately 1 year. This is typically delivered by a transperineal approach using needles that are placed under transrectal ultrasound (TRUS) guidance. The procedure does not require a surgical incision and the seeds (figure 1), which are smaller than rice grains are accurately guided into their final position within the prostate gland under visual guidance.

Volume Study

Before an implant can be performed, the patient must undergo a volume study. This determines the exact size and position of the prostate. It is performed in theatre and requires a short anaesthesia. Using a TRUS probe, the radiation oncologist makes custom outlines of the prostate gland from the top to the bottom of the gland at 5mm intervals (figure 2). These outlines are then entered into sophisticated planning computers to generate a three dimensional model from which the prostate implant can be planned. The exact number of radioactive seeds, the seed activity and the precise location the seeds need to be placed in the prostate gland is determined from our planning computers creating an implant map. This custom-designed map is used during the implant procedure to place the seeds precisely within the gland.

The Implant Procedure

The implant procedure is performed in theatre and lasts one to two hours. A general or spinal anaesthesia may be used. At the beginning of the procedure, a urinary catheter is inserted. A TRUS probe is also inserted into the rectum providing direct visualisation of the prostate. Approximately 20 to 30 needles are inserted into the prostate gland. Each needle is implanted under direct visualisation of the TRUS probe and can be seen on the ultrasound screen. A template, or guiding device, is attached to the TRUS probe (figure 3). The template is used to guide the needles directly into the precise, pre-planned locations in the prostate gland. On the template is a series of holes, coded A through G horizontally and 1 through 5 vertically (figure 4).

Prior to the procedure, the radioactive seeds are placed into needles and arranged in a protective box. The needle box is also coded A-G and 1-6, to match the template. Each needle is positioned in the needle box in an arrangement that corresponds to the location in the template through which it will pass.

To begin the procedure, the ultrasound probe is inserted into the rectum, providing direct visualisation of the prostate. The template is attached to the probe, fitting close to the perineum. A grid is activated on the ultrasound screen that correlates with both the template and needle box coordinates. The grid is superimposed over the prostate gland. Each needle may contain 2 to 6 radioactive seeds, based on the computerised treatment plan. Once the needle is in the proper location in the prostate, the seeds are implanted into the prostate gland as the needle is withdrawn. Depending on the gland size, usually 20-30 needles are inserted into the prostate gland through the perineum, implanting 60 to 80 seeds (figure 5).

The urinary catheter will remain within the bladder for 24 hours and the patient is discharged the next day.

Post Implant

I^{125} emits low energy radiation. Most of the radiation is confined to the prostate gland and the immediate surrounding area. Small amounts of radiation can reach other persons such as close by individuals. This amount is not considered a risk for most people and there are no restrictions in traveling or contact with other adults.

Growing children or a growing fetus within a pregnant woman may be sensitive to the effects of radiation. As such children and pregnant women are advised to stay six or more feet away from the patient. Very brief encounters for hugging and saying hello are allowed. Patients are advised to follow these radiation precautions for two months following implantation with I^{125} .

Complications

There is not a significant amount of immediate morbidity associated with the procedure. Most patients have irritative voiding symptoms (urinary frequency, urgency and dysuria), which is maximal at 4 weeks. These bothersome

symptoms may uncommonly persist for several months. Prophylactic alpha blockers are now used to minimise the risk of radiation and needle induced obstructive urinary symptoms.

Long-term toxicity is minimal with <10% of patients complaining of persistent urinary symptoms 2 years post implantation (8). In this same study, 60% of previously sexually potent patients remained so at 3 years of follow up.

Results

PB has been associated with excellent *PSA relapse free* ^{2*} survival rates ranging from 80% to 90% at 10 years in patients with early stage prostate cancer (9). The Seattle Prostate Institute has recently completed their 15-year follow up with PSA relapse free survival comparable to any surgical series (personal communication). Trials to determine the relative effectiveness of surgical and radiation therapy are currently underway. They will provide critical information about the relative advantages of these different treatment options. In the meantime, prospective studies have shown no difference in PSA relapse free survival in patients undergoing RRP versus PB (10) or 3D conformal radiotherapy/IMRT versus PB (11).

Summary

In discussing treatment options for early stage prostate cancer: patient age, life expectancy and patient preference must be taken into account. Watchful waiting in elderly men with a life expectancy of <10 years may be the most reasonable option. They are most likely to die with their prostate cancer rather than of their prostate cancer. Age should not be an absolute contraindication to treatment. A 65-year old man has a mean life expectancy of 19 years, a 70 year old man has a life expectancy of 16 years and an 80 year old man has a life expectancy of 10 years.

There still exists considerable debate regarding the use of radiation therapy either external beam therapy or PB versus surgery in patients with early stage prostate cancer. Importantly long term results are no different between the three modalities. In general, patients who are young (< 60-years), with multiple foci of disease on biopsy may be best treated with surgery. In elderly patients with a life



Fig 1 Needle and rapid strand seeds

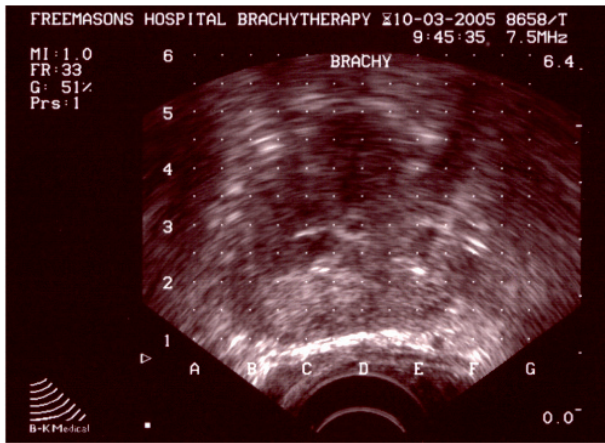


Fig 2 TRUS image of mid prostatic gland

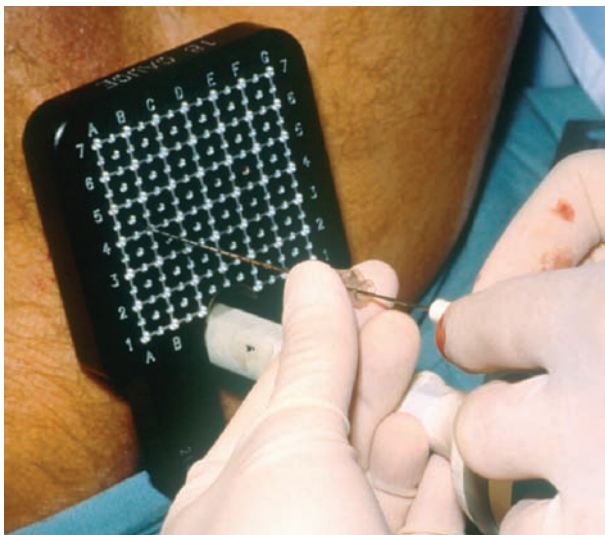


Fig 3 Template attached above the TRUS probe with needle insertion

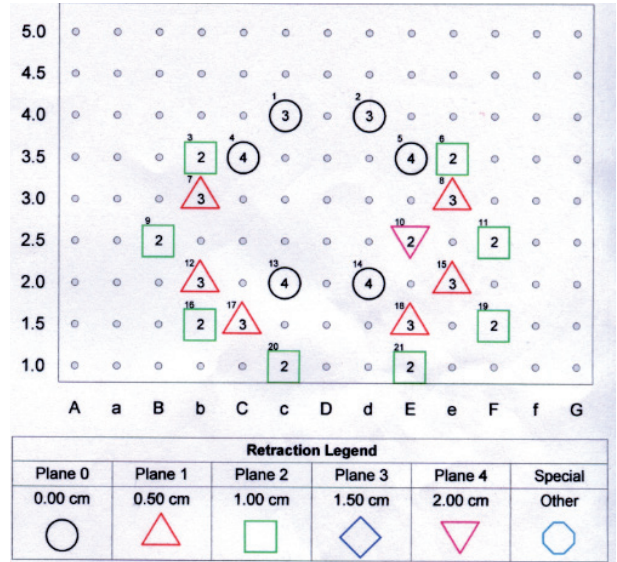


Fig 4 Template demonstrating position of needle placement

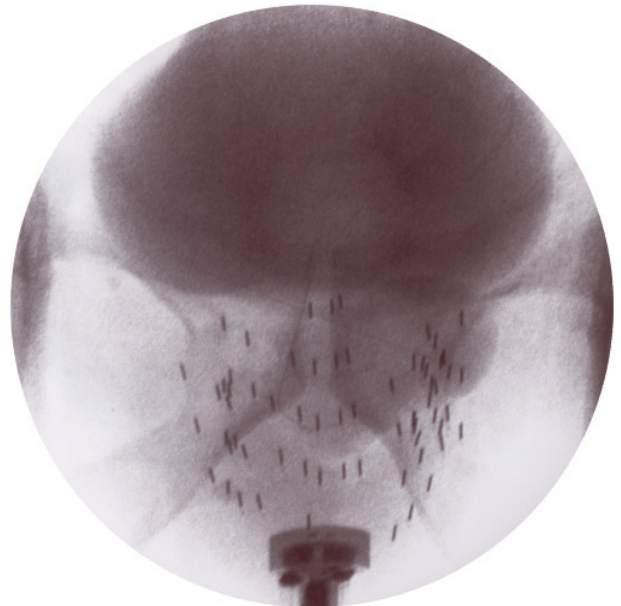


Fig 5 Fluoroscopic image of seed positions within the prostate post implant

expectancy of < 10-years with significant co-morbidities, radiation therapy is more appropriate.

The real conundrum arises among generally healthy patients who are aged 65 to 75 years. Personal choice will play a significant role. Surgery offers a rapid one off procedure in patients with definitive pathologic diagnosis, requiring hospitalisation, a general anaesthesia and with possible complications - impotence and incontinence. EBRT is well tolerated in older men and does not require hospitalisation but requires daily treatment visits for 7.5 weeks. It results in a lower risk of impotence when compared with surgery and the incidence of incontinence is also low. The major long-term complication is late rectal bleeding in < 5% of patients.

PB also offers a rapid one off procedure without the requirement of a general anaesthesia. The implant procedure takes 1 to 2 hours and requires overnight hospitalisation only. Normal activities can resume within a couple of days. The risk of incontinence is low and there is no adverse bowel sequelae. The procedure is better tolerated than surgery or EBRT. The only downside is minor irritative symptoms and potential exposure to young children thus requiring simple precautions.

Footnote:

1* *JARROC* Joint Austin ROV Royal Marsden Oncology Collaboration

2* No rise in three consecutive PSA readings as currently established for post therapy surveillance

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Erectile Disorders

Nam Wee Kour

With social evolution, sexual topics are no longer taboo, and problems with sexual function are now not uncommon presenting complaints. Here, I would like to present a quick overview of the physiology and pathophysiology of erectile function and dysfunction, the problems we encounter, how we assess and treat the patients, and some practical tips in dealing with such situations.

By far the most common problem is inadequate erection (or impotence). Sometimes we see patients with curvatures of the penis, with or without pain, whilst priapism (excessively prolonged erection) is an uncommon problem.

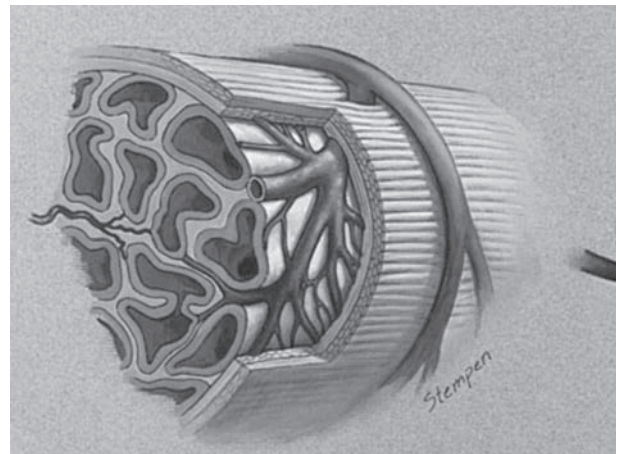
Impotence

There is considerable variation in what a person or a couple perceives as normal sexual function. There are some who are quite happy with vaginal penetrative intercourse only once a month, whilst some others feel inadequate if they do not have successful and sustained penetration two or more times in a 24-hour period. Expectations therefore are an issue, and often, there may be a mismatch between the expectations of the partners. There are also considerable ethnic and cultural differences. We therefore approach this problem in a goal-oriented manner, attempting to achieve a situation which is optimal to the couple. The male partner must not be treated in isolation.

It is estimated that at the age of 40 years, about 1 in 50 men in a Western society have impotence (as defined by the inability to penetrate at least 50% of the time when attempting intercourse), but this would increase to at least 1 in 4 for men over 65 years of age. To understand this better, let us look at erectile physiology and pathophysiology.

which has healthy vascular channels which can fill up, and remain engorged in a sustained fashion. This entails the release of neurotransmitters at nerve terminals in the penile cavernous tissue to cause this vasodilatation, and hence a functioning neural system, from the central areas all the way to the nerve terminals. The whole process is modified by endocrine influences. If there should be abnormalities in any of these processes, there will therefore be inadequacies in the erectile response. Vascular disease, neurologic abnormalities, cavernosal inadequacies, and hormonal problems are therefore logical causes of impotence. In addition, psychogenic influences, drugs and other systemic diseases which disturb these basic functions can disrupt the normal erectile response.

When we see a young newly married man who has erectile difficulty, we have to be on the lookout for possible hormonal or even genetic/chromosomal abnormalities. On the other hand, if the patient is a 70 year old man with a history of diabetes and coronary artery disease, the likelihood



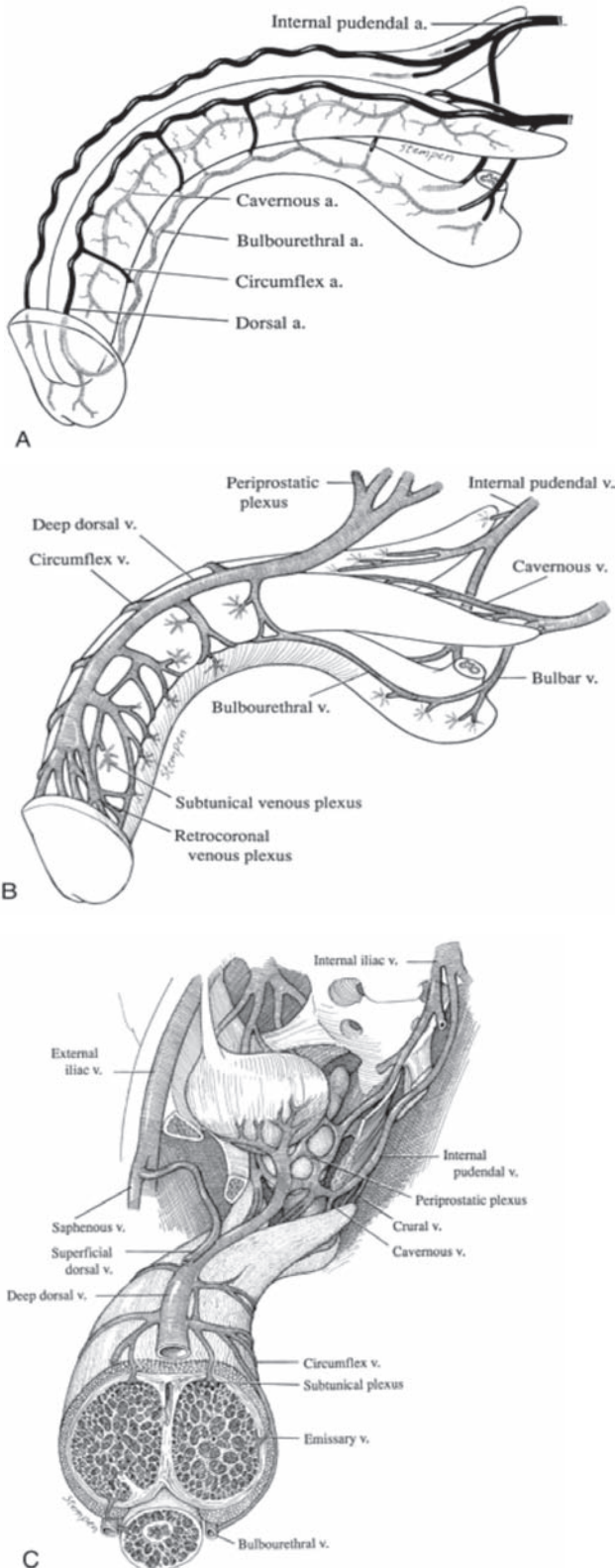
Mechanism of penile erection. Muscles of the sinusoidal wall and arterioles relax, allowing maximal flow into the sinusoidal spaces. Venules are sandwiched and flattened by the distended sinusoids and the noncompliant tunica albuginea. The penis then becomes engorged. (From Lue TF, Akkus E, Kour NW: Physiology of erectile function and dysfunction. Campbell's Urology Update #12 1994;1-10.)



The Physiology and Pathophysiology of Erection

To be able to achieve a good erection, one needs to have a penis

Nam Wee Kour
Consultant Urologist



A. Penile arterial supply – longitudinal view
 B. Penile venous drainage – longitudinal view
 C. Transverse and longitudinal views of venous return

(From Lue TF: Physiology of penile erection and pathophysiology of erectile dysfunction and priapism. Campbell's Urology 8th Ed. vol. 2 2002;1591-1618.)

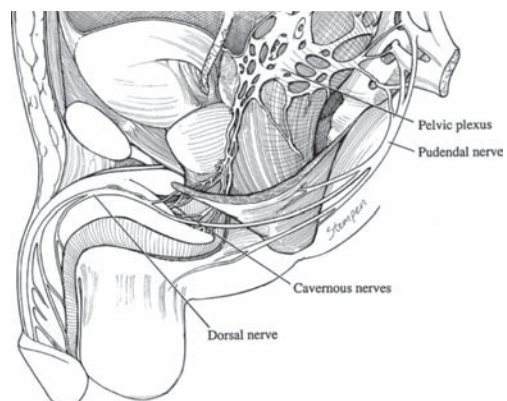
Organic

- I. Vasculogenic
 - A. Arteriogenic
 - B. Cavernosal
 - C. Mixed
- II. Neurogenic
- III. Anatomic
- IV. Endocrinologic

Psychogenic

- I. Generalized type
 - A. Generalized unresponsiveness
 - 1. Primary lack of sexual arousability
 - 2. Aging-related decline in sexual arous ability
 - B. Generalized inhibition
 - 1. Chronic disorder of sexual intimacy
- II. Situational type
 - A. Partner-related
 - 1. Lack of arousability in specific relationship
 - 2. Lack of arousability due to sexual object preference
 - 3. High central inhibition due to partner conflict or threat
 - B. Performance-related
 - 1. Associated with other sexual dysfunctions (e.g., rapid ejaculation)
 - 2. Situational performance anxiety (e.g., fear of failure)
 - C. Psychological distress or adjustment-related
 - 1. Associated with negative mood state (e.g., depression) or major life stress (e.g., death of partner)

Classification of male erectile dysfunction. (From Lizza EF, Rosen RC: Definition and classification of erectile dysfunction: Report of the Nomenclature Committee of the International Society of Impotence Research. Int J Impot Res 1999;11:141-143)



Penile neuroanatomy. Note the proximity of the cavernous nerves to the prostate.

(From Lue TF: Physiology of penile erection and pathophysiology of erectile dysfunction and priapism. Campbell's Urology 8th Ed. vol. 2

is more a vasculopathy with or without some neuropathy. On the other hand, if we see someone who is 50 years old, has no problems with his mistress, but fails each time with his wife, it is more a psychogenic and situational cause. A man who was functioning well previously, and has become impotent after a radical prostatectomy almost certainly has cavernous nerve injury. Our clinical assessment is therefore very important in helping us direct our investigations and treatment.

Importance of concomitant diseases or problems

We know that in more than 50% of cases of men who present with erectile difficulties, there is an organic aetiology. We should therefore take the opportunity to assess the individual better, as there may be important health issues which we can correct and improve. Examples of such a situation would be the undiagnosed diabetic, the asymptomatic man with significant coronary artery or peripheral vascular disease, the man with unsuspected hyper-prolactinaemia, etc. It is also an opportunity for the couple to explore any possible relationship difficulties which may not have been verbally expressed, but which can be improved upon. I therefore see every case of impotence as an opportunity to improve the individual's and also the couple's general health, and a chance to provide some medical education such as cessation of smoking, weight and dietary control, exercise and other aspects of healthy living. It is not just a matter of doling out Viagra or its equivalent.

Assessment

Simple blood assessment for diabetes, dyslipidaemia, prolactin and testosterone levels can be carried out easily. However Doppler or angiographic studies, or other more invasive and sophisticated investigations such as Rigiscan, cavernosography, etc will entail referral to a centre of interest.

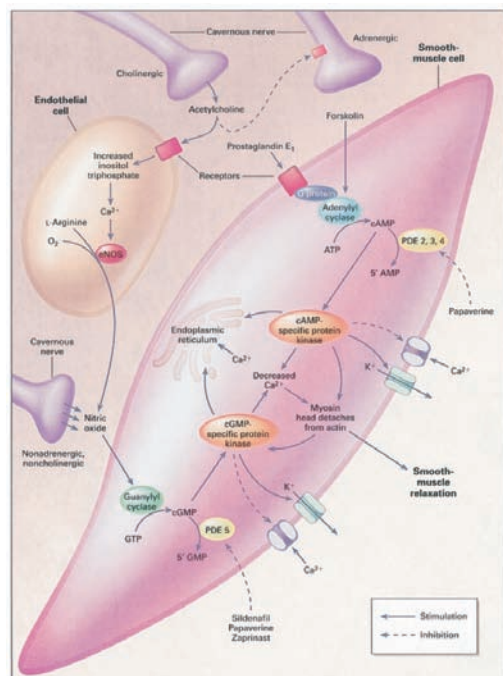
Treatment

I shall dwell more on non-surgical medical therapy here, as surgical options such as penile implants or revascularisation would be more in the remit of the specialist surgeon. Similarly, more extensive psychological techniques would

require the sex therapist. Currently the mainstay of treatment would be the oral phosphodiesterase-5 inhibitors (PDE5 inhibitors) and to a lesser extent now, injectable alprostadil (also known as prostaglandin-E1). Other oral agents such as centrally acting alpha-2-adrenergic agonist Yohimbine, serotonergic drugs like Trazodone, and dopaminergic agonists Apomorphine, are hardly used due to their poor efficacy and also adverse effects. Other injectables such as Papaverine and Phentolamine are rarely used nowadays, as they too have more significant problems with priapism and fibrosis. Other treatments for more specific problems such as hyperprolactinaemia will not be dealt with here. The use of testosterone (either by injection, orally, or by transdermal patches) remains controversial except for those with a clear cut indication. The use of the vacuum pump has diminished due to its poor efficacy.

Oral Phosphodiesterase-5 Inhibitors

These work by enhancing the cGMP-NO (nitrous oxide) pathway via inhibition of the PDE5 enzyme which breaks down the neurotransmitter. This inhibition allows accu-



Molecular mechanism of penile smooth muscle relaxation. PDE5 inhibition increases intracellular cGMP inducing smooth muscle relaxation. (From Lue TF: Erectile dysfunction. N Engl J Med 2000;342:1802-1813)



Welcome back Tiger ♦

Why do patients keep coming back for Viagra? Confidence!



Before prescribing, please refer to Approved Product Information. Full Approved PI is available on request from Pfizer. Viagra (sildenafil). Indication: erectile dysfunction in adult males; not indicated in women. Contraindications: hypersensitivity, concomitant nitrates, cardiovascular risk factors/conditions making sex potentially hazardous. Not studied in severe hepatic impairment, blood pressure >170/110 mmHg or <90/50 mmHg, recent stroke or myocardial infarction, hereditary degenerative retinal disorders (e.g. retinitis pigmentosa). Precautions: combination with other therapies for erectile dysfunction, left ventricular outflow obstruction (e.g. aortic stenosis, hypertrophic obstructive cardiomyopathy), multiple system atrophy, anatomical deformation of the penis (e.g. angulation, cavernosal fibrosis or Peyronie's disease), predisposing conditions for priapism (e.g. sickle cell anaemia, multiple myeloma, leukaemia), bleeding disorders, active peptic ulceration, diabetic retinopathy, pregnancy, lactation, driving/operating machinery. Adverse reactions: headache, flushing, dyspepsia, nasal congestion, urinary tract infection, abnormal vision, diarrhoea, dizziness, rash. Dose: initially 50 mg oral dose one hour before sex, increased to 100 mg or reduced to 25 mg based on efficacy and tolerability. Maximum one dose in 24 hours. Reduced dose in elderly, hepatic or renal impairment, with concomitant inhibitors of CYP 3A4. Pfizer Australia Pty Limited, ABN 50 008 422 348, 38-42 Wharf Road, West Ryde NSW 2114. Reference: 1. Althof SE et al. *Urology* 2003; 61: 888-92. www.pfizer.com.au @Registered trademark of Pfizer Inc. 08/04 PFV15649



PBS information: This product is not listed on the PBS.

mulation of the neurotransmitter in amount and duration, hence a stronger and more durable erectile response. It is important to understand this, as it means that taking the PDE5 inhibitor will have no effect if there is no stimulation to release the neurotransmitter. The man who pops the pill and sits by the bedside waiting for things to happen will be sorely disappointed. Similarly, for a man who has a good response with half a tablet, will not get a much better response with 2 or even 3 tablets, as there is only so much neurotransmitter released.

Sildenafil (Viagra)

The most well known of these is Sildenafil (Viagra). It was released for sale over 10 years ago and there was the initial hype being the first orally effective treatment, followed by concern due to the reported associated deaths. Since then, sense has prevailed, and we are now more able to use Viagra more appropriately. We now know that it is actually a relatively safe drug, with quite a wide therapeutic margin of safety. However, it is contraindicated for those who are already on nitrates for other reasons. Caution should also be exercised for those with a poor cardiac functional status, not because of the direct effect of Viagra, but because of the associated strain of sex. It is not contraindicated in those being treated with anti-hypertensives, but again one needs to watch for aggravated hypotension. For most men, it will take about 30 minutes to an hour before a response is noted, and its effect can be retarded by a large meal or alcohol just before that. Most of its effect is gone by about 5 hours, although some men report a sustained effect of up to 12 or more hours. Common side effects include headache, mild light-headedness, a ruddy appearance, a stuffy nose, epigastric discomfort, and in some there is visual disturbance with blue tint images. There has been some recent concern about loss of vision, but so far, this has not been confirmed. Some of these effects are attributed to cross-over effect with other PDE subtypes in other tissues. It is notable that it has been tried in those with pulmonary hypertension and some cyanotic babies, in large continuous doses. Useful doses for erection range from 50-100 mg as required, not more than once daily. Some patients report a faster onset of response with crushed tablets, which could be due to a better absorption. This also allows the user to titrate the amount more precisely.

Vardenafil (Levitra) and Tadalafil (Cialis)

These are two other PDE5 inhibitors which have since become available to the public. Their use and effects are very similar to Viagra, with some minor differences. Levitra is reported to have a faster onset (10 to 15 minutes), with a similar duration. There appears to be less retardation in effect with meals. Cialis on the other hand has been reported to be effective for up to 36 hours. However, it seems to need a longer time (2 hours) for onset. Similarly, food seems to affect it less. Otherwise, the adverse effect profiles are similar to Viagra. It is however worth trying a different agent in those who do not obtain a good response or have bothersome adverse effects with one particular PDE5 inhibitor. Levitra is available as 10 mg or 20 mg tablets, and Cialis as 20 mg tablets. We usually advise patients not to exceed 1 tablet in 24 hours.

We do not advise combining PDE5 inhibitors of different types, or with other treatments such as Alprostadil injections, although some adventurous patients would try these combinations. There may be a risk of priapism, or other unknown adverse events.

Alprostadil (Prostaglandin-E1)

This was the mainstay of treatment until the advent of oral Viagra. Alprostadil is best delivered by intra-cavernosal injection, but has been tried as a transurethral application (MUSE – medicated urethral system for erection) and topical sprays with poor results. A common brand is Caverject, which is better known. The intracavernosal preparation comes in a powder form which has to be diluted, and has to be stored in the refrigerator. For these reasons, combined with the need to have it injected and the associated discomfort, there is poor acceptability. Also it has a small risk of inducing priapism, especially in those who are injudicious with their doses. Although less popular now, it is still useful in those who have poor responses to PDE5 inhibitors. It has also been combined with Papaverine and Phentolamine (known as the 3 P's), and although effective remains a cumbersome agent to deliver.

Trial of Treatment

Once we have assessed a patient, and feel that major problems have been excluded, and there are no other

significant correctable abnormalities, it is not unreasonable to give a trial of oral PDE5 inhibitor. It can also be useful in those with mainly a psychogenic cause, as it does give them a boost which can help with their confidence in their performance.

Penile Curvatures including Peyronie's Disease

Some of these curvatures are congenital, and they may cause not only a bent but also a spiral, or mild corkscrew type curvature. If it is functionally good, and patient is satisfied, no action is needed. Otherwise surgical correction is necessary.

Peyronie's Disease, which is still poorly understood, can be a painful and progressive disease, and it results in fibrosis of the tunica albuginea causing a restrictive effect which leads to curvature and impotence. Some medical therapy including antioxidants such as vitamin E, Colchicine, Potaba and even intralesional injections of Verapamil have been tried with variable success. If severe, surgical excision of the plaque and correction of the curvature or even implantation of penile prostheses may be needed.

Priapism

Priapism is an excessively sustained erection. Any erection which exceeds more than 4 hours constitutes an emergency, as untreated, there may be permanent damage to cavernosal endothelium which can result in impotence. Drug use is often the cause, and this includes injudicious use of Papaverine or even Alprostadil, some anti-psychotic medicines, as well as recreational drugs such as cocaine. Such cases are best sent for emergency attention, but if specialist care is not immediately available, simple measures such as cold compress, cold showers, etc. can be tried. Aspiration followed by intracavernosal injection of an alpha-adrenergic agonist (adrenaline or noradrenaline) may be given with care, failing which pudendal artery embolisation or even surgical drainage may be required.

Suggested reading

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Andrology Australia's snapshot of reproductive health in middle aged and older Australian men: MATeS (Men in Australia, Telephone Survey)

Megan L Cock, Carol A Holden, David M de Kretser

Andrology Australia, Monash Institute of Medical Research, Monash Medical Centre, Melbourne (MATeS was conducted by Andrology Australia with financial support from the Australian Department of Health and Ageing.)

Introduction

Male reproductive health encompasses a range of disorders (prostate disease, erectile dysfunction, lower urinary tract symptoms (LUTS), infertility) and reproductive behaviours (sexual activity, contraception). Despite these disorders representing the major aspects of male reproductive health, each of these issues are usually viewed or studied in isolation. In addition, while it is known that advancing age impacts on male reproductive health (1), many studies have explored issues of reproductive health including sexuality, fertility and contraception almost exclusively in younger men or in women (2, 3). There is limited information regarding male reproductive health in the older Australian population, with much of our knowledge based on large international studies.

The Men in Australia Telephone Survey (MATeS) was commissioned by Andrology Australia to collect information on self-reported prevalence rates, health behaviours in relation to sexual activity, fertility and contraception, as well as attitudes and concerns of middle aged and older Australian men. The outcomes of MATeS represents a unique dataset and the first accurate picture or "snapshot" of reproductive health in Australian men over the age of forty. A distinctive feature of MATeS is its comprehensive focus on male repro-

ductive health as a whole, which differs from most surveys that are restricted to single health issues.

This review of the MATeS study summarises the major findings and highlights recommendations directed to improve men's reproductive health in Australia, and other developed countries with an increasing ageing population.

Methods

The methodology used in MATeS has been described previously (4, 5). In summary, between September and December 2003, computer-assisted telephone interviews of a representative sample of men from across Australia, aged 40 years and over, were undertaken. The required number of completed interviews was based on age and population distributions within the States and Territories from the 2001 Census (Australian Bureau of Statistics, 2003). Within each State and Territory, respondents were stratified into four age groups: 40–49 years, 50–59 years, 60–69 years and 70+ years. Sampling continued until a minimum of 1250 men in each age stratum had been surveyed.

Respondents were recruited by random selection of households from the electronic telephone directory (Electronic White Pages, EWP). The study was approved by the Southern Health Human Research Ethics Committee, Melbourne.

Telephone survey instrument

The telephone survey instrument included more than 90 questions focusing on socio-demographic issues (age, marital status, ethnicity, occupation and education), general health and lifestyle, sexual function, relationship issues, and knowledge, attitudes and beliefs concerning male reproductive health and its disorders. The full CATI is available at <http://www.andrologyaustralia.org/survey/codebook.pdf>.

Using the Massachusetts Male Aging Study (MMAS) single question, ED was described



David de Kretser
Endocrinologist,
Future Governor of Vic.



Megan Cock
Endocrinologist



Carol Holden
Endocrinologist

as the respondents current erectile function as defined as 'sometimes' (moderate) or 'never' (severe) being able to get and keep an erection that is rigid enough for satisfactory sexual activity. LUTS were assessed using the International Prostate Symptom Score (IPSS) and defined as absent or mild (score <7), moderate (score >8-<19), or severe (score >20-<35) over the past month. Included as part of the IPSS, nocturia was defined as the respondent indicating that, over the past month, he got up on average 2 or more times a night to urinate. A self-reported diagnosis of prostate disease was indicated if the respondent noted that a doctor had ever told them they had a prostate problem. Men indicating that there had a prostate problem were also asked the course of treatment taken. Men reported suffering from "perceived symptoms" of androgen deficiency when providing a positive response to the question 'Do you think you may currently be suffering from low levels of testosterone now?' Self-reports of other specific diseases were noted when men reported receiving a specific diagnosis or prescribed medication by a doctor.

Data analysis

Sample proportions were weighted according to age and state of residence, with weighting based on the 2001 Census age distribution of Australian men. Descriptive analyses were performed using SPSS software (SPSS Inc., Chicago IL, USA) and Intercooled Stata 8.0 statistics package (Stata Corporation, College Station, Texas).

Results

From a total of 7636 randomly selected households with an eligible male, 5990 men (78%) agreed to participate in the study. Results from MATeS have previously been published in detail (4, 5).

General health

More than 85% of men over the age of 40 years had visited a doctor in the 12 months, with almost all (98%) older men (70+ years) using health services. Men in the oldest group (70+ years) reported more cardiovascular disease and diabetes and use of prescription medicines than did other age groups. Overall, 64% of men were overweight or obese (BMI >25kg/m²) and in relation to physical activity, 65% of all men were either sedentary or had insufficient physical activity.

Prevalence and concerns of reproductive health disorders

Overall, 34% of men surveyed, reported one or more reproductive health disorder. Reproductive health disorders were more common amongst older men (Figure 1), with 80% of men aged 70+ years reporting at least one of prostate disease, lower urinary tract symptoms (LUTS) or erectile dysfunction (ED).

Erectile function declined with age with 21% of men over 40 years reporting ED (Figure 1). ED peaked in men aged 70+ years (68%), with this oldest group of men also reporting the lowest level of sexual activity. Despite 80% of men being concerned about losing their erectile function (Figure 2), only 30% of men with ED sought medical help. The age-standardised prevalence of prostate disease was 14% and for LUTS was 16% in men aged 40+ years and these were most frequent in the oldest age group (prostate disease, 38%; LUTS, 29%)(Figure 1). Moderate to high level concern about prostate cancer (57%) (Figure 2) was reflected by half of the men undergoing testing (PSA ±DRE) for prostate cancer. More men in the oldest age group thought they suffered symptoms of low levels of testosterone compared to younger men (Figure 1).

Sexual activity

The proportion of men having sexual activity in the last 12 months was 78% of men over 40 years; this proportion was lower in older age groups, but it was still maintained with 37% of men over 70 years reporting continuing sexual activity (Figure 3). At all ages, men desired sexual activity more frequently than presently, including 27% of men aged 70+ years. Although the frequency and desire for sex was lower in the older age groups, sexual physical pleasure with a partner was the same at all ages.

Fertility and contraception

Overall, 12% of men had never fathered children, of whom over half (8% of the total population surveyed) had chosen not to have children. Questioning on failed attempts to produce a pregnancy suggested an involuntary infertility rate of 8%.

The vasectomy rate in men over the age of 40 years was 25%, with 6% of vasectomised men having no children. Although 9% of vasectomised men regretted sterilisation,

only 1% had undergone vasectomy reversal. Of the men aged 40 years and older in a current sexual relationship, 10% used condoms with their regular partner. However, in regard to STI prevention, 41% of men having a casual sexual relationship do not use condoms.

Discussion

The prevalence of reproductive health disorders and associated concerns in middle-aged and older Australian men is high. Although men expressed much concern about prostate cancer and loss of erectile function, concern about reproductive health was lower in older age groups. Australian men continued to be sexually active into older age, and many of those in casual sexual relationships were not using condoms. The high response rate of the survey ensures that the results are representative of the diverse Australian population and these findings represent an accurate picture of reproductive health in Australian men.

This national study reinforces the finding that advancing age is a key predictor of self-reported prevalence of male reproductive health disorders, notably erectile dysfunction, LUTS and prostate disease (6, 7). Despite the high level of health service utilisation reported and the high level of concern, there was a strikingly lower level of specific enquiry and treatment for reproductive health disorders. This was highlighted with the significant gaps between concern, health seeking behaviour and the prevalence of ED. In contrast, the high level of concern about prostate cancer was reflected by a large proportion of men in the survey seeking testing for prostate cancer, despite the medical and health policy consensus in Australia which does not support population screening for prostate cancer (8). Taken together, these findings suggest that making better use of doctor's visits and other opportunistic strategies may be an effective way to educate men more about their health.

Contrary to the current dogma, this study shows that older Australian men continue to be sexually active. While frequency and desire for sexual activity declines with advancing age, sexual physical pleasure with a partner did not change with age. This information is important outside the medical focus. For instance planning of accommodation for older couples needs to take into account their continuing sexual activity and need for intimacy. With men being sexually active at older ages, issues of contraception, STI prevention and fertility are of increasing importance. Few

studies have previously explored fertility and contraceptive issues in older men (9). The high rates of vasectomy reflect the fact that Australian men are keen to be involved in family planning. In contrast, failure for many men in casual relationships to use condoms indicates that safe sex practices are being ignored by older men and increasing their risk of STI infection (10). With a stereotypic image of older people being sexually inactive, improved research, education and policy is needed to ensure that age-related barriers to seeking information and treatment for sexual and reproductive health issues do not persist for older men.

In regard to fertility and fatherhood, while there are some men who never want to have children, there are many men without children who would still like to be fathers. This is the first study to estimate the rate of involuntary infertility (8%) in Australia, which has implications for health policy and education.

With a recognized association of reproductive health disorders with age (1) and lifestyle factors (6) more men are expected to seek help in the future as these issues become more widely recognized as significant health problems for the older male. In addition, identifying younger men at risk of developing reproductive health disorders as they age will be essential to develop appropriate preventative strategies and direct health services and policy with age-appropriate goals for the older male population. The high prevalence of reproductive health disorders and associated concerns, combined with a low level of specific enquiry, in a representative Australian population of middle-aged and older men highlight the need for better use of doctor's visits and other strategies to ensure men are educated about their reproductive health.

Future studies

MATeS highlights the need for larger, longitudinal cohort studies to gain a better understanding of incidence and progression of disease and determine risk factors and behaviours that may contribute to the onset of health disorders in older men.

Acknowledgements

We acknowledge the substantial work on MATeS of all members of the Andrology Australia Longitudinal Group, Prof Robert McLachlan (Prince Henry's Institute of

Fig 1

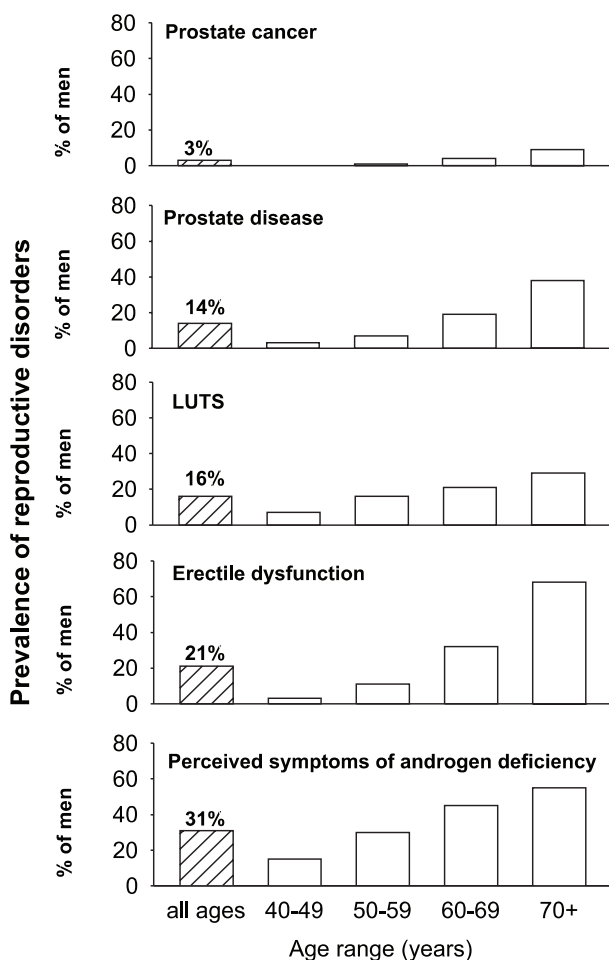


Fig 2

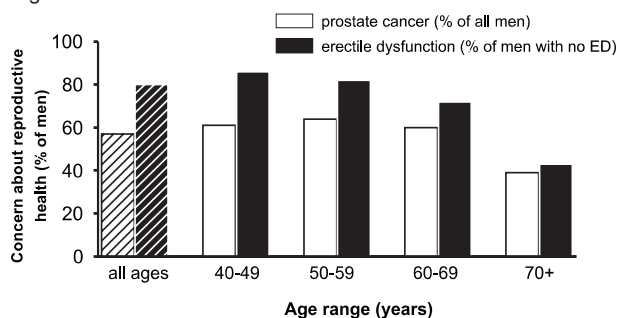


Fig 3

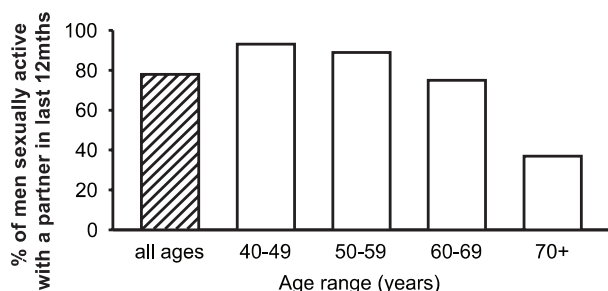


Fig1: Prevalence of male reproductive disorders.

The prevalence of perceived prostate cancer, prostate disease, lower urinary tract symptoms (LUTS), erectile dysfunction (ED) and perceived symptoms of androgen deficiency (pAD) across age (40-49, 50-59, 60-69 and 70+ years).

Fig 2: Concern about male reproductive disorders.

The concern about developing prostate cancer (solid bar) and erectile dysfunction (open bar) across age (40-49, 50-59, 60-69 and 70+ years).

Figure 3: Sexual activity.

Men having sexual activity with a partner in the past 12 months across age (40-49, 50-59, 60-69 and 70+ years).

Medical Research, Melbourne, Vic), Prof Marian Pitts (Australian Research Centre in Sex, Health and Society, La Trobe University, Vic), Prof Robert Cumming (Centre for Education & Research on Ageing and Department of Public Health & Community Medicine, University of Sydney, Sydney, NSW), Prof Gary Wittert (Department of Medicine, University of Adelaide, Adelaide, SA) and Prof David Handelsman (Department of Andrology, Concord Hospital, ANZAC Research Institute, University of Sydney, Sydney, NSW). We thank the Australian Department of Health and Ageing for the financial support needed to undertake this study; the Hunter Valley Research Foundation, for administration of the survey.

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Sexy Men's Health

Vanita Parekh

Young men (and many older men too) spend a lot of time considering the issue of what makes a man appear to be sexy. A lot of media attention is directed at sex and sexuality, indeed many of our society's ideas about what constitutes being sexy are formed through media hype. It is time to discuss some of the issues around what makes a sexy man, without the influences of someone trying to sell beverages, cars or shaving razors.

Having good general health

Medical professionals often ignore their own health issues and routine health care. While, women have the often-inconvenient Pap smear which at least links them to the health system on a two-yearly basis, men have very little in terms of prompts to get them through the door to have their health reviewed and in the Australian "it'll be all right, mate" culture, it becomes easy to let health issues slide as not being enough of a problem to bother with at the moment. However, having good general health is a prerequisite to having good sexual health and relationships. Furthermore, part of good general health is good mental health that is receiving media attention now, and hopefully will raise the profile of mental health issues.

Good sexual health

Good sexual health for both sexes revolves around good general health, a healthy lifestyle, and managing sexually transmitted infections, dealing with issues of sexual assault, and being happy with your choices around pregnancy.

Our society has fostered an expectation that men are the initiators of sexual activity and that penetration is the be all and end all of a sexual relationship. These expectations are

huge and we should remember that we have the ability to determine our own sexual repertoire providing that all concerned willingly consent to these sexual activities.



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Sexually transmitted infections are infections that are mostly asymptomatic which, of course, means that you could have one and not know that you have it. The implications are wide-ranging and all people, including health professionals, need to consider the possibilities and consequences of being exposed to one of these infections without attaching a stigma or blame for having a "sexual disease". We all focus on the big HIV campaigns, but Hepatitis B is another virus that can be sexually acquired and is prevalent in the Chinese community, with a large number of individuals who have been infected vertically (mother to child transmission) without their knowledge. Treatments are available for Hepatitis B carriers and vaccination is available for sexual contacts. It is worth both being tested yourself and asking your partner to be tested. Should either of you be carriers or have evidence of previous infection then you may also wish to consider organising testing for your children.

Syphilis testing occurs routinely in Australia as part of the antenatal screen because the effects of syphilis can significantly affect the newborn child. This is also true of virtually all sexually transmitted infections which is another good reason to get yourself tested. Chlamydia and gonorrhoea can be completely asymptomatic and it is definitely worth being tested, as both can cause infertility in men and women (this can be done on a urine sample, without the person having to expose their genitals). Genital herpes has implications for pregnant woman, especially those who acquire genital herpes in pregnancy. If you have symptoms that you think may be genital herpes, then do see a doctor, but again the majority of people with genital herpes are asymptomatic. Genital warts can be easily treated with a variety of creams and lotions that can be self-administered.

There are clearly a variety of infections that can be spread through sexual contact. If you are worried, please ask someone who knows. Your local sexual health clinic is a good place to start for accurate information without bias. A list of these clinics can be found at http://www.acshp.org.au/sexual_health/clinics/.

Sadly, sexual abuse is common with 1 in 20 men experiencing some form of sexual coercion¹. If this has ever happened to you, it is most important to remember it is not your fault and you are in no way to blame. While it is not an indication of weakness, it is a form of trauma and support groups are available. This website, http://www.acshp.org.au/sexual_health/assault.htm, can help to direct you to those in your area.

Male doctors in particular may find it difficult to access help with regard to sexual health issues, including sexual dysfunction and sexual abuse issues, as there are very few 'pap smear' equivalent ice breakers for them to use unbroaching these topics which remain hugely uncomfortable for discussion in our society. Perhaps going for a routine check up with your general practitioner and saying that you are aware that hepatitis B is prevalent in the Chinese population could be a start.

Good relationships

Relationships are vital to our existence. All doctors need to ask if they are allowing medicine to ruin our sex life and relationships. According to Rissel et al, most couples in Australia have sex on average 1.84 times per week². That figure can be quite daunting, but it is important to remember that it is an average!

Medicine requires certain personality traits, including thoroughness, being obsessive, conscientiousness, being committed. Doctors also feel the need not to be wrong, to be good communicators, to be compassionate and to have endless time for our patients which leaves us with little energy for anything else. There may also be an inability to relax, low self-esteem and a poor sense of self when they don't meet the targets they set for themselves. Thinking convergently and divergently at the same time is another trait that doctors develop which also can contribute to their ability to be stressed and unable to focus on their sex lives. Doctors also need to acknowledge that their work place has changed. They may feel that they have limited power to change work conditions, and be under pressure from time demands which inevitably leads to an effort/reward imbalance. All of these traits and factors may lead to more vulnerable relationships with patients and partners.

There are certain things we can do to enhance our relationships which I will identify below. The beginnings and ends

of relationships put people at increased risk of sexually transmitted infections, sexual assault and unintended pregnancy and doctors and nurses are not immune to these. It is always important to allow yourself to get in and out of relationships, safely. Being in the middle of a relationship is not a no-effort situation either. We need to be conscious that that is where we are and that all relationships require maintenance. In medical speak, we need to keep up our quota of CME points of relationships.

These keys to successful relationships include:

- Recognising that good relationships are good for you.
- Making your relationship the priority
- Courting each other forever
- Expressing your love each day
- Recognising the needs of your partner
- Realising that differences can be resolved
- Make time together, it sounds strange but this includes planning time and intimacy, even though spontaneity may be difficult we can build anticipation in our relationships. Further hints on making a better sex life can be found in some bedside reading by Dr Rosie King 'Good Loving Great Sex'. David Schnarch's book 'Passionate Marriage' provides an approach rather than techniques.

So, with all that on board I hope that you will be able to be sexy, safely. Although the realities can be challenging!

There is potential for all sexual and relationship counselling to be tricky, it must be stated that advice offered to patients is in the context of a therapeutic relationship only.

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An approach to the patient with asymptomatic microscopic haematuria

Fiona Y.F. Chow

One of the commonest reasons for referral of a patient to a nephrologist is for asymptomatic microscopic haematuria detected on routine screening as part of immigration assessment or defence force entry. In fact, routine screening for haematuria is not currently advocated in the general population for the following reasons: it is extremely common (possibly affecting up to about 16% of the population even transiently); it is in the vast majority of cases benign, and cost effectiveness has not been demonstrated. However, if haematuria has been detected on routine testing, a suggested approach is outlined below.

The possibility of malignancy as the cause for the haematuria will often be the greatest concern for patients. In men over 50 years of age with asymptomatic microscopic haematuria, urological malignancy will be responsible in up to 1-5% of cases, but in patients under 40 years, urological cancer is very unlikely.

| Causes of haematuria |
|---|
| Transient unexplained |
| Contamination (menstrual, endometriosis of urinary tract) |
| Benign exercise-induced haematuria |
| Trauma |
| Urinary tract infection – cystitis/prostatitis/urethritis/pyelonephritis (including tuberculosis) |
| Glomerular disease |
| Calculi (renal/ureteric/bladder) |
| Malignancy or benign polyps (renal/ureteric/bladder/prostate) |
| Polycystic kidney disease |
| Benign prostatic hypertrophy |
| Papillary necrosis |
| Renal infarction |
| Factitious |
| Rarer causes e.g. loin pain-haematuria syndrome, arteriovenous malformations etc |



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Approach to the Patient

History

Age (increased age is risk factor for malignancy)

Has the patient ever had macroscopic haematuria?

If so, was the haematuria at the start of the stream (urethral), mixed in (upper tract), or at the end of the stream (bladder/prostatic pathology)?

Are there any symptoms such as pain (stones) or dysuria (urinary tract infection) or prostatism (benign prostatic hypertrophy)?

Did the patient have any other illness such as an upper respiratory tract infection at the time of or prior to urine test (IgA nephropathy/post-infectious glomerulonephritis)?

Check relationship of MSU to benign causes:

- Last menstrual period
- Any vigorous exercise
- Sexual activity
- Urological instrumentation
- Rectal examination

Past history of:

- Renal disease (polycystic kidneys, glomerulonephritis)
- Prostatic disease
- Renal stones
- Urinary tract tumours
- Urinary tract infection
- Other illnesses e.g. liver disease and inflammatory bowel disease are associated with IgA nephropathy, hepatitis may be associated glomerulonephritis

Medication history:

- Analgesic abuse (analgesic nephropathy)
- Anticoagulants
- Cyclophosphamide (associated with bladder cancer)

Family history of:

- Thin basement membrane disease
- Glomerulonephritis
- Polycystic kidney disease
- Renal cell carcinoma

Risk factors for bladder cancer – smoking history, exposure to aniline dyes

Examination

General inspection – rash (lupus, vasculitis, Henoch-Schönlein purpura, cryoglobulinaemia)

Vital signs – hypertension (renal disease)

Cardiovascular examination – murmurs (subacute bacterial endocarditis, which can be associated with glomerulonephritis), peripheral oedema may suggest renal disease

Abdominal examination – renal mass (polycystic kidney disease), renal bruits (arterio-venous malformation), liver enlargement (polycystic liver), signs of chronic liver disease

Respiratory examination – crackles / crepitations (fluid overload, pulmonary vasculitis)

Rectal examination – prostatic enlargement

Investigation

MSU x 3 – for pyuria (infection), quantification of haematuria
Phase contrast microscopy – glomerular vs. non glomerular haematuria

24 hour urine collection or spot urine protein/creatinine ratio – proteinuria suggests glomerular disease

Renal ultrasound – renal size, presence of 2 kidneys, polycystic kidneys, renal masses, calculi

CT urogram – has greater sensitivity for calculi/masses than ultrasound

IVP – is less sensitive than CT scanning for calculi/masses, thus is less commonly performed

Full blood examination – to look for evidence of anaemia of chronic renal disease

Coagulation screen - if contemplating renal biopsy

Urea and electrolytes – to assess renal function

Liver function tests – look for evidence of liver disease

Serum calcium, urate – if suspect renal stone disease

PSA – if non glomerular haematuria, if suspect prostate disease

If suspected glomerulonephritis, consider *glomerulonephritis screen*:

- Anti-nuclear antibody
- Anti-ds DNA and ENA
- Complements 3 and 4
- Hepatitis B and C serology
- Serum protein electrophoresis – may show elevated IgA levels in IgA nephropathy
- Anti-GBM serology
- ANCA

Consider renal biopsy if evidence of renal disease – glomerular haematuria, impaired renal function, proteinuria

If patient has non-glomerular haematuria:

Urine cytology x 3 (sensitivity for urological malignancy around 70%)

Consider cystoscopy if risk of significant urological disease:

- Age > 40 years
- Smoker or ex-smoker
- Any macroscopic bleeding
- Past history of urological disease e.g. stones
- Past occupational exposure to chemicals – benzenes, aromatic amines
- Exposure to drugs e.g. cyclophosphamide, phenacetins, HIV treatment
- Systemic disease – SLE, HIV, vasculitis, schistosomiasis
- History of pelvic irradiation
- Past history of urinary tract infections or history of irritative voiding symptoms

Consider *urine for TB PCR and culture* if associated sterile pyuria
(See diagram)

#If likely glomerular cause (renal impairment, proteinuria, casts)

- Consider renal biopsy if indicated (refer to a nephrologist) – although patients with isolated haematuria with normal renal function and no proteinuria are often best managed with observation as limited data suggest that in the majority of such cases, the diagnosis is IgA nephropathy or thin basement membrane disease, where a renal biopsy does not alter management.
- Consider screening family.

- # If likely non-glomerular cause
 - Consider referral to a urologist for cystoscopy, especially if at risk for malignancy (see below)
 - If the patient refuses cystoscopy and is at risk, follow-up with serial cytology would be appropriate after imaging has not shown a definite lesion

- # If indeterminate cause:
 - * If low risk patient (without factors listed above*):
 - Consider sending urine for cytology (and consider cystoscopy if patient is concerned)
 - If negative, then follow up with blood pressure, MSU, urine cytology at 6,12, 24 and 36 months
 - * If high risk patient (with risk factors listed above*):
 - Needs CT urogram and cystoscopy
 - If negative then follow up with blood pressure, MSU, urine cytology at 6,12, 24 and 36 months

- # If no cause is found
 - In up to 60-70% of cases, there is no definite cause identified.
 - If no cause is found, then consider follow up with MSU and blood pressure yearly for 3 years then 2 yearly.
 - If MSU then becomes negative for haematuria for 3 consecutive visits, follow-up could be ceased.
 - If haematuria persists and patient develops hypertension or proteinuria, it would be appropriate to reevaluate for a glomerular cause.
 - If a patient subsequently develops gross haematuria, abnormal cytology, irritative symptoms without infection, work-up should be repeated.

Conclusion/Learning Points

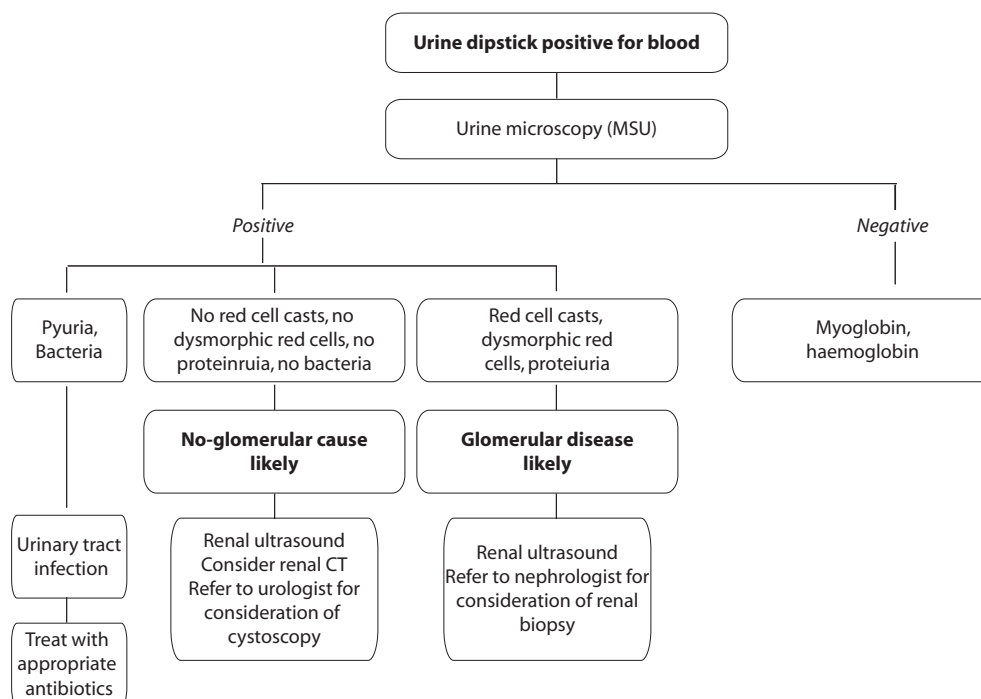
1. Asymptomatic microscopic haematuria is common.
2. Routine screening of urine is not recommended in the general population as the yield of significant disease is low, it leads to many patients undergoing expensive tests with negative results, and cost-effectiveness is not demonstrated. However, once asymptomatic haematuria is detected on routine testing, further evaluation should be carried out.
3. In up to 70% of cases, no definite cause is found but in most cases, the cause is benign.
4. The presence of proteinuria requires serial monitoring as patients may need to proceed to renal biopsy. Referral to a nephrologist may be appropriate.
5. Referral to a urologist for cystoscopy is recommended in patients with no evidence of a renal cause for haematuria, especially in patients over the age of 40, as urological malignancy must be excluded
6. If no cause is found, periodic follow-up is required, as a small percentage of patients with negative investigations may have malignancy detected several years later.

Suggested Reading:

Up-to-Date version 13.3 – Evaluation of hematuria in adults

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Depression in the Elderly Patient

Eng-Seong Tan

Depression, or more precisely depressive illness, is now recognised as one of the more common diseases in existence. It is variously estimated at one in five people presenting to a general practitioner and the incidence is expected to rise for a number of factors which are in operation or coming into operation. This situation is recognised by the World Bank as an important factor in the economic functioning of the world so that it has appointed a psychiatrist to sit on its governing board. In Australia the importance of this disorder is recognised by the establishment of an organization 'Beyond Blue' to promote awareness of this disorder and to study various aspects, including the causes and treatment of this disease. This point is underscored by news reports of prominent people admitting that they have suffered from depression.

Incidence

Depression can start in a person at any age. It is not unknown among children. It is common in adolescence. The high rate of suicide among young males in rural Australia is a fact of great clinical significance. The incidence of depression is highest among people of the middle age and older. Depression is associated with the onset of menopause in women and with retirement. The experience of the loss of a spouse, loved ones and friends are more common to older people. This bereavement can bring on an episode of pathological grieving and a state of severe depression.

Clinical features

Depression can present in many forms. The usual lowered mood, slowing of thinking and activity, loss of appetite and loss of weight, insomnia and a feeling of hopelessness are typical presenting symptoms. The hopelessness could lead to suicide in any age, but is most common in the older age groups.



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Depression can also present with other symptoms. Physical symptoms are often associated with depression, but may present by themselves. For patients who continue to complain of symptoms for which there is no physical basis, a high index of suspicion that they are suffering from depression will have to be maintained. For such patients, extended investigations which look into exotic disorders may only serve to entrench the idea that they are having an incurable disorder. This is referred to as the *somatization* of the symptoms of depression. Insomnia is often a presenting symptom of depression.

A not uncommon mode of presentation of depression among the elderly is a complaint of memory loss. Psychometric testing often does not reveal any cognitive deficits and when the depression lifts the memory function returns to normal. This is referred to as a *pseudo-dementia*.

Severe and chronic pain, especially in older people, which is not relieved effectively with analgesics could give rise to a state of depression, partly from the experience of the unrelenting pain and partly from the pharmacological effect of the narcotic analgesic. This is not depressive illness.

Diagnosis

The best way to diagnosing a depressive illness is to take a good clinical history of the onset of the illness, which may be abrupt, usually associated with a loss of some sort, particularly a bereavement. The onset can be gradual over a period of weeks and a few months. The depressive illness in later life could be a recurrence of a depression which had occurred when the patient was younger.

Management

It is important to help the depressed patient sort out any problems in his or her life or rectifying a situation. The patients will have to be helped to accept those problems

which are not rectifiable, such as a bereavement. Practical measures may need to be instituted to make living easier especially in old age.

Since the 1950's, effective antidepressant drugs have been available, so that the need to resort to electro-convulsive therapy is greatly reduced. The older tricyclic (TCA) and monoamine oxidase inhibitor (MAOI) antidepressants used to take 10 days to 3 weeks to work and was lethal in the hands of a suicidally depressed patient who lived alone. The new serial serotonin reuptake inhibitors (SSRI) antidepressants are much more effective and are relatively free of side-effects. The important feature of this group of drugs is that they take effect in a few days as opposed to the long latency period of the TCA and MAOI antidepressants. The major drawback of these drugs is the individual responsiveness to each compound; some patients will respond to one compound while other patients will respond to another. The only way to find out which patient will respond to which drug is to individual trial.

Drug interactions

Treating elderly patients with antidepressant medication can be tricky because these older patients are already on an array of medication for other complaints. The interaction may produce adverse reactions with other drugs the patient is already on. An example of this is the use of Tramadol for chronic pain; this drug will interact with the SSRI antidepressants.

Summary

Depression is now recognised as one of the most frequently occurring disorders in the world.

Depression is more prevalent after middle age than in younger age bracket.

Depression can manifest in many forms.

The usual and most recognisable form is a lowered mood state and a slowing down of mental and physical functions.

It could present with physical symptoms for which no pathological basis can be found.

- Obsessional symptoms and panic states.
- Insomnia.
- Pseudo dementia

Diagnosis:

A good history is most important.

Management:

Sorting out any life situations causing difficulty or anxiety. Antidepressant medication.

Watch for interaction with other medication the elderly patient is already on.

The Place of Alternative Medicine/Therapy in Men's Health

Choong Khean Foo

Men in general think they are invincible. They never admit to being 'unwell' or 'sick'. They usually blame somebody or something else for their feeling of "being off". They blame their 'new' shoes for their 'unsteady gait'; tomato sauce for 'vomiting up bright red coloured fluids'; "There is nothing wrong with me" or "I am alright" when they are asked, "How are you?" And when they finally admit that they are 'not alright' they become almost impossible to live with! They are very difficult patients! This obstreperousness is compounded when the patient is a medical doctor!

Men are meant to be strong and not seen as 'weaklings' by the opposite sex even if they are their wives! Hence by the time I see male patients, they usually are in the advanced stages of their 'sickness journey'. They usually present with very dramatic symptoms like renal colic, acute urinary retention, acute chest pain, erectile dysfunction, cancer, and so on.

The main health issues confronting men are centred on, according to Traditional Chinese medicine terminology, the "Lower Triple Energiser" which is located in the lower abdominal and pelvic areas. Men do suffer from similar medical conditions as their female counter parts. However they have illnesses which they can proudly call uniquely "their own". In this article, I will touch on four common topics concerning Men's Health or Ill Health:

1. Andropause
2. Erectile Dysfunction
3. Benign Prostatic Hypertrophy
4. Prostate Cancer

Andropause

"Life begins at 40". So when men reach their 40s, they start to notice physical and emotional changes. They develop central obesity, nocturia, receding hairline

(with a tint of gray on the side-burn!), decreased libido and sexual performance and their zest for life has declined along with their libido and receding hairline. With time these changes may be accompanied by benign prostatic hypertrophy, along with fatigue and depression, and other more serious illnesses like prostate cancer.

In men the decline in testosterone is the single most important cause of Andropause.

The hormone testosterone gives men the male characteristics of 'manhood'. It's anabolic properties affect the cholesterol levels, protein breakdown, muscle mass and bone density, and sexual functions such as libido and erection capability.

Testosterone is the end product of a cascade of biochemical reactions from the hypothalamus secreting Gonatotropin-releasing Hormone (GnRH) to that of Luteinising Hormone (LH) which stimulate the Leydig cells in the testis to produce testosterone. The secreted testosterone is either free or bound to sex hormone binding globulin (SHBG). It is the free testosterone, which exerts its anabolic and androgenic effects on the human body. The fate of the testosterone doesn't just end there. It can also be converted into dihydrotestosterone (DHT) by the enzyme 5-alpha reductase or into oestrogen by the enzyme aromatase. Although oestrogen is known as a 'female hormone', it plays a vital role in men's health, including sexual function, bone mass and cognitive function.

Alternative Treatment for Andropause:

To help reduce the effect of andropause men should eat a well-balanced diet consisting of fresh, organically grown fruits and vegetables and avoiding endocrine-disrupting chemicals. It is also important to take a well-balanced multivitamin and minerals with a full complement of antioxidants and other essential nutrients. This is necessary because foods don't contain all the nutrients that are



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required by our body. Exercise will help keep the heart and muscles fit and also help us to keep a lean body mass. Moreover regular high intensity exercise will help elevate the testosterone hormone for both young and elderly men.

High Protein Diet

Protein is essential for the body to maintain optimal health. Low protein diet may lead to elevated SHBG levels, which will lead to decrease free testosterone in elderly men. The decreased bioavailability of testosterone will lead to decrease in sexual function, red cell mass, sarcopenia and osteopenia/osteoporosis. It is therefore important for middle aged men to have adequate protein intake.

Soy

Ageing men have elevated levels of oestrogen through the activity of the enzyme aromatase, which converts testosterone to oestrogen. It is postulated that soy products may inhibit the aromatase enzyme and help keep the oestradiol level low.

Fish oil

Fish oil has many health benefits and one of the beneficial effects of fish oil (EPA & DHA) is to cause a decrease of SHBG in elderly men.

Zinc

Zinc is involved in almost every aspect of male reproduction, including testosterone metabolism, sperm formation and sperm motility. Adequate zinc intake is essential for the healthy function of the male reproductive system by increasing the testosterone level and increasing the sperm count.

Indole-3-carbinol (I3C)

Studies have demonstrated that I3C increases the ratio of 2-hydroxytestosterone to 16-alpha-hydroxytestosterone, thereby causing a decrease in "bad" estrogen and an increase in "good" estrogen. I3C is found in the cruciferous vegetables. Most Chinese vegetables like Choi Sum, Kai Lan (Broccoli), cabbage and others are cruciferous vegetables.

Dehydroepiandrosterone (DHEA)

This steroid hormone is secreted by the adrenal glands and

is transformed into testosterone and oestrogen. The level of DHEA declines with age and by restoring the DHEA to youthful levels in older adults, it will help improve their energy levels, quality of sleep, mood and ability to handle stress.

Testosterone Supplementation

There is a growing body of evidence that supplementation of testosterone will help men to overcome some of the andropausal symptoms like depression, loss of energy, libido and erection capability as well as help arrest or reverse the devastating effects of sarcopenia and osteoporosis

Until all the secrets of aging are discovered, men cannot stop the advance of time and andropause. Meanwhile we should treat our bodies with respect by eating a wholesome, organically based diet, doing regular exercise and taking supplements to help alleviate some of the tell tale signs of ageing in men as well as to maintain our vitality and zest for life.

Erectile Dysfunction

Time has changed. Once upon a time, sex and contraception were taboo topics at dining table. Since the introduction of Viagra and Cialis we begin to talk openly about our sex life. We are spending mega bucks trying to get the erectile dysfunction (ED) corrected.

Erectile dysfunction is "*a consistent or recurrent inability to achieve or maintain penile erection sufficient for satisfactory sexual function.*" From record sale of Viagra and Cialis, we realise this disorder is more common than we hitherto thought. It has been estimated that ED affects an estimated 152 million men worldwide, with a rate of 50% of men aged 40-70 in the United States. Normal erection requires a dynamic balance of excitatory and inhibitory forces and it occurs through "*the synchronized action of psychological, neuronal, hormonal, vascular, and cavernous smooth muscle systems*", very much like a symphony orchestra performing an exquisite piece of work.

Management of ED

As with all medical problems, it is important to manage the underlying cause by modifying lifestyle factors such as managing stress, smoking, alcohol consumption, obesity and diabetes. Medication for hypertension, lowering of cholesterol levels and depression can affect ED. It is there-

fore very important to review the drug chart and to replace those drugs wherever possible. Where appropriate psychotherapy including sex counseling and behavioural therapy should be instituted along with the other treatment. It is important for men to remain physically and sexually active for as long as possible otherwise as the old adage says, “*use it or lose it*”!

With ageing the total and free testosterone concentrations are decreased, the testosterone to estradiol ratio is reduced; the levels of DHEA, DHEA-sulfate, thyroid hormones, growth hormone, and melatonin are decreased. Also with ageing, SHBG is increased which will result in a decrease in concentration of free testosterone. Testosterone deficiency is likely to be a primary contributor to sexual dysfunction in many cases of erectile dysfunction.

In young men, testosterone is converted to DHT, androstenediol and estradiol. With ageing, the conversion of testosterone to DHT and estradiol is increased along with the production of SHBG. These changes will reduce the amount of free testosterone in the body. With this knowledge, we can try to prevent the conversion of testosterone to DHT by using supplements to block the enzyme *5-alpha reductase* and using natural aromatase inhibitors like progesterone and zinc to prevent the conversion of testosterone to oestradiol. A third way to elevate free testosterone level is by prescribing nettle root extracts (*Urtica dioica*) to inhibit the binding of the testosterone to SHBG.

When hormonal deficiencies or imbalances are found in ED, it will be appropriate to prescribe bio-identical hormones to help manage the problem. Replacement of androgens can be crucial in restoring normal physical, mental and sexual function of men over 40.

Alternative Treatment of ED

Herbs have been used for centuries both in the east and west for ED. Korean red ginseng is the most popular one of them all especially in the east. The other herbs and supplements that are reported to help ED are *L-arginine*, *zinc*, *maca root*, *Tribulus terrestris*, *horny goat weed*, *oat straw*, *damiana*, *muiira puama* and *aslwagandha*. Yohimbine, an alkaloid derived from the African tree, *Pausinystalia yohimbe*, has been used for over 70 years as a pharmacological agent in treating ED.

There is sense and science in the use of various herbal supplements:

- **Saw Palmetto** inhibits *5-alpha* reductase in the prostate gland and also acts as an alpha-adrenergic receptor inhibitor, reducing urinary urgency and inflammation in the prostate gland.
- **Nettle Root** extracts (*Urtica dioica*) inhibits 5-alpha reductase and its has a great affinity for SHBG which blocks the free testosterone from being bound to SHBG.
- **Pygeum Africanum** inhibits prostate cell proliferation and enhances healthy prostaglandin function.
- **Zinc** inhibits the enzyme aromatase
- **Progesterone** is a natural inhibitor of 5-alpha reductase as well as aromatase inhibitor.
- **Chrysin** is a flavonoid which is a natural aromatase inhibitor
- **Ginger root** is a powerful anti-inflammatory phytonutrient by inhibiting inflammation mediators such as prostaglandin E2 and thromboxane B2.

Benign Prostatic Hypertrophy

The conventional view of benign prostatic hyperplasia (BPH) is due to the stimulation of dihydrotestosterone (DHT) on prostate cell proliferation. DHT is more active than testosterone for binding to the sites of the prostate cells that regulate prostate growth. The common medications used for treatment of BPH are Saw Palmetto and the drug Finasteride, which inhibit *5-alpha-reductase*, the enzyme required to convert testosterone to DHT. By reducing DHT production it may help to reduce the growth of the prostate gland.

Prostate growth is directly under the influence of male androgenic hormones. Why then does BPH occur in ageing male when the testosterone and free testosterone levels are on the decline? Obviously there must be another explanation for this anomaly. It has been found that BPH is due to the imbalance of the oestrogen and testosterone. When compared to younger men, the ratio of free oestradiol to free testosterone is up by 40% higher in older men.

This was confirmed by a recent Japanese study that showed that prostate size correlates with estradiol level and with the ratio of estradiol to free testosterone. They suggest that “*the endocrine environment tended to be estrogen-dominant with age, in particular, after middle-age, and that patients with large prostates have more estrogen-dominant environments*,” They concluded that “estrogens are key hormones for the induction and the development of BPH.”

Over the recent years many alternative herbal remedies have been discovered which could help to slow the progression of prostatic hypertrophy. An extract of the root of the stinging nettle plant, *Urtica dioica* can inhibit the binding of SHBG to the prostatic cell membrane. However the method of extraction is important for the therapeutic outcome. It is the methanolic extracts of nettle root that inhibit SHBG binding and not the ethanolic extracts. There are other constituents in the nettle root that inhibit the enzyme aromatase, which normally converts testosterone to oestrogen. Pygeum has also been shown to inhibit aromatase. When used in combination, nettle root extract and pygeum work better synergistically to inhibit the enzyme aromatase.

Another new phytonutrient that may reduce BPH is the extracts from the combined pollens, marketed as Cernitin. Cernitin has been shown to improve prostatic function in relieving the subjective symptoms, especially obstructive and irritative symptoms as well as the urine flow, decreased residual urine volume and prostate volume. Like all nutraceuticals, it takes time (over 3 months) for the beneficial effect to be experienced.

Other supplements and phytonutrients that have been shown to promote prostate health are: Rosemary, Omega 3 Fatty Acids and Lycopene.

Prostate Cancer

Men's life expectancy is extending so has the incidence of prostate cancer, which is increasing. From the epidemiological data and eating habits researchers have been able to identify the foods and supplements that may help to prevent and control prostate cancer. The phytonutrients and supplements that are shown to be able to do this are - Vitamin E (notably gamma tocopherol & gamma tocotrienol), Saw Palmetto, Lycopene, Selenium, Omega 3 fatty acids, Soy isoflavones and Green tea polyphenols.

Vitamin E Complex

There are eight different forms of vitamin E in nature but most commercial vitamin E supplements contain mainly alpha tocopherol. At the John Hopkins School of Public Health, they evaluated 10,456 men over a seven-year period measuring the vitamin E levels and the incidence of prostate cancer. According to the study published in the Journal of the National Cancer Institute (20th December

2000), "*men who had the highest blood levels of gamma tocopherol were five times less likely to get prostate cancer*". Gamma tocopherol is required to trap and neutralise existing free radical while alpha tocopherol inhibits the production of free radical.

Research from the Children's Hospital in Boston demonstrated that *saw palmetto* extracts slow the growth of prostate cancer cells. They also found it reduced the expression of cyclooxygenase-2 (COX-2) which associated with an increased incidence of prostate cancer; so by decreasing the COX-2 expression it may provide a risk reduction for prostate cancer.

Lycopene

Over the past decade researchers have found that the consumption of fresh and processed tomato products is associated with reduced risk of prostate cancer. Lycopene, a member of the carotenoid family, is a potent antioxidant, which could be the principle reason for the reduction in risk of prostate cancer. Also there are many other compounds present in tomato such as folate, vitamin C, other carotenoids, phytochemicals such as polyphenols, potassium, vitamin A and vitamin E. Possibly it could be the combination of all these compounds with lycopene that contribute towards the anti-cancer effect.

A 6-year study done at Harvard University involving 50,000 men revealed that those who ate foods high in lycopene were up to 45% less likely to develop prostate cancer. In another double-blind study, patients treated with lycopene had smaller prostates than an untreated control group. And some cancer patients who received lycopene showed signs of cancer regression. In other words, lycopene slowed the growth of the cancer, and possibly its further spread.

Selenium

When the researchers analysed 13 years study of the Nutritional Prevention of Cancer Trial, they were able to show that "*Selenium supplementation was associated with marked reductions in risks to total (all-site except skin) carcinomas and to cancers of the prostate and colo-rectum*".

Nutritional recommendation

Is there an ideal diet to prevent and 'treat' prostate cancer? Various components of food have been identified, eg. fat intake, the type of fat, the absorption of vitamins, trace

elements, antioxidants (beta-carotene, lycopene), phyto-oestrogens, including soybean may constitute nutritional factors involved in prostatic carcinogenesis. Researchers are endeavouring to find the type of food and nutrients that will help prevent cancer. Although the ideal diet is unknown at the present time, some of these ingredients appear to be good candidates, such as *unsaturated fats, soybean proteins, carotenoids, lycopene, vitamin E, selenium and saw palmetto*.

New role of PSA in Prostate Cancer

Prostate-specific antigen (PSA) is the protein synthesized in the prostate gland. Estimation of PSA serum level is used as a screening test in order to detect prostate cancer at an early stage, or it is used to assess the efficacy of various prostate cancer treatments. Until now PSA has been viewed only as a blood indicator of prostate cancer, infection, or inflammation. Research scientists are gathering evidence to suggest that PSA may be more than just a marker of prostate pathology. It appears that PSA itself may play a role in the progression and spread of prostate cancer. This may add a new dimension in the total management of prostatic disease. If that is the case, finding nutrients that have anti-PSA activity may help to prevent or slow the progression of prostate cancer.

The incidence of prostate cancer is much higher than that reported clinically. Autopsy report have shown histological evidence of prostate cancer in 34% of men aged between 40-49 and 70% of men over 80 years old.

The latest research shows that at cellular level, PSA functions as an active growth factor in the prostate gland. *“Through its enzymatic ability, it can degrade extracellular matrix proteins, freeing insulin-like growth factor 1 (IGF-1) from its binding protein, providing increased local levels of IGF-1 and leading to tumor growth”.*

Boron, Soy & Curcumin

In a report from UCLA showed that men with the highest dietary boron intake reduced their prostate cancer risk by 54% compared to men with the lowest boron intake!

It has long been known that those who consume *soy products* have a lower risk of prostate cancer. Scientists have evaluated the effects of soy on PSA and other prostate cancer-related blood markers in men who had already developed prostate cancer. The investigators concluded that

men who consume diets high in soy might have a reduced risk of prostate cancer and its progression.

Numerous studies over the past two years have identified specific mechanisms by which *Curcumin inhibits* the growth of prostate cancer cells, activating genes that tell cancer cells to self-destruct (apoptosis).

One study showed that Curcumin reprograms prostate cancer cells so as to make them less likely to metastasize to the bone, while another study demonstrated its radiation-sensitizing effects, making cancer cells more vulnerable to destruction by conventional radiation therapy. The research on Curcumin is so promising that pharmaceutical companies are currently developing Curcumin analogs that can be patented as anti-cancer therapy.

In summary, accumulated data suggest that PSA is no longer merely a laboratory test of prostate gland activity but a functional protein: an enzyme that may facilitate prostate cancer cell proliferation, invasion, and spread. Many natural supplements like lycopene, soy, green tea, and boron can achieve reduction in PSA levels. Conventional prescription drugs such as Proscar and the newer Avodart can reduce serum PSA levels by as much as 40-50%.

At the 96th Annual Meeting of the American Association for Cancer Research in April 2005, the Italian researchers reported the finding that compounds in green tea prevented progression of high-grade Prostatic Intraepithelial Neoplasia (PIN) to prostate cancer in 90% of the study subjects. This is the first in-vivo study to demonstrate the protective action of green tea catechins.

Concluding Remarks

There is a place for everything in life. Nature provides us with all the herbs and spices to help us maintain optimal health. Most of the drugs are derived from plants or synthetically made, mimicking Mother Nature's formula. Given a choice I would prefer to choose the less harmful natural alternative for treatment and management. If we look after ourselves from the very start, there won't be a need for drugs and medications. The secret is to live in harmony with nature. Wherever possible use what Mother Nature has provided, then health is ours forever.

Editor's Note: It has been quoted that men who are bald at the vertex of the scalp are said to be “sexy”, whilst those, balding in the frontal area are “thinkers”. Those with balding in areas stretching from frontal to occipital areas “think they are sexy”.

Geriatric Assessment for the General Practitioner

Irene Tan

Comprehensive Geriatric Assessment (CGA) is a multi-dimensional and often multidisciplinary diagnostic process used to assess an older patient's medical, cognitive, functional and psychosocial problems. The process of the geriatric assessment involves identifying problems, forming a comprehensive plan for therapy/ management, monitoring status and if necessary, accessing other regional services or programs for the elderly, such as community programs, rehabilitation services or specialist clinics. CGA has been shown to have significant benefits on mortality, place of accommodation, physical and cognitive function, and hospital readmission. (Struck et al 1993)

Although CGA is a fundamental part of a specialist geriatrician's practice, general practitioners have a significant role in the assessment process. Nevertheless, general practitioners often feel excluded and want more involvement. ((Hebblewhite 1995) Given that we face an ever aging population, more pressure will be put on pre existing geriatric services. It is not unreasonable to anticipate that general practitioners will need to play an increasingly active role in the care of their elderly patients. It is possible for them to practice a modified form of the CGA as a means of screening for problems which may otherwise be overlooked. Early intervention is invaluable as it has implications on prevention of morbidity, treatment and prognosis. Increasingly, more treatment options are available which has greater benefits at the early stages of a disease spectrum. A good example is the use of acetylcholinesterase inhibitors in Alzheimer's Disease.

Although it is not within the scope of this article to discuss every aspect of the CGA, there are key areas, apart from the medical and physical examination, which are part of every assessment, namely cognition and function. The assessment can take place in a clinic, hospital or the patient's residence. Cognitive assessment is best carried out in a quiet environment to minimise distractions. The use of sensory aids (glasses, hearing aids, good lighting) and a professional interpreter, if required, optimise conditions for the patient.

It is widely accepted that functional assessment is best performed in an environment familiar to the patient. It allows more direct and accurate assessment of the patient's ability to function within the context of his/her social support network. Traditionally, general practitioners have performed home visits and this provides the opportunity for them to incorporate some aspects of the geriatric assessment into their daily practice with many practitioners already performing this function.

Cognitive Assessment

The history of cognitive decline is most commonly volunteered by an informant, usually the caregiver or a relative. For the older person who lives alone with minimal social or family contact, much can be derived from the person's grooming, hygiene and general appearance. The state of the household may provide clues - eg. unpaid bills, rotting food in the fridge, burnt pots, accumulation of rubbish and general state of disrepair. Hopefully, this scenario is becoming less common as the community and health professionals become more aware of onset of dementia. Early signs of repetitiveness, forgetting appointments, needing reminders, non compliance with medication or disorientation while driving are probably more helpful to alert the general practitioner of patient's cognitive dysfunction.

The Mini Mental State Examination (MMSE) is one of the more widely accepted screening test for mental status. (Folstein et al 1975) It consists of 30 questions, assessing orientation, memory, attention, calculation and language.(Table 1) It is important to point out that the MMSE is purely a screening test and in itself, not diagnostic of dementia. The interpretation of the score takes into account educational level, cultural background and sensory impairment. The MMSE is also a useful tool to monitor any change in mental status of a patient. For example, the expected decline in untreated mild to moderate Alzheimer's Disease is between 2 to 4 points a year. (Doraiswamy 1996)

Irene Tan
Consultant Geriatrician

Other commonly used cognitive screening tests are the Abbreviated Mental Test (AMT) (Table 2) and the Clock-face Drawing. (Death et al 1993)

Functional Assessment

Functional assessment covers 2 broad domains, namely Personal Activities of Daily Living (PADL) and Instrumental Activities of Daily Living. (IADL) Each component is graded according to whether a task is performed independently, assisted or totally dependent.

PADL covers

- Feeding
- Bathing and Dressing
- Mobility
- Transfers
- Toileting
- Continence

The information is derived from direct observation and history from the client and/or caregivers. It is worthwhile noting that functional capacity can fluctuate particularly if there are concomitant medical conditions, eg arthritis, chronic obstructive pulmonary disease

A simple test of mobility is to ask the patient to rise from a chair, walk a short distance, turn around, walk back and sit down. Much information can be obtained from this task eg gait pattern, use of aids, balance, transfer ability and footwear. A patient who has had 2 or more falls in the last 12 months or 1 or more injurious falls requiring hospitalisation or medical treatment is likely to benefit from a Falls and Balance Service (FABS)

Bladder and bowel function is often a neglected area although it has significant impact on a person's physical, mental and emotional health, notwithstanding the implications of conditions of accommodation. Often the odour of stale urine on the patient's clothes or furniture is a revealing sign, especially if no collaborative history is available. A few simple questions such as those below will help to identify if there is a problem.

1. Do you go to the toilet frequently?
2. Do you go to the toilet more than twice a night?
3. Do you experience urinary leakage when you get to

the toilet too late?

4. Do you leak urine with activity?
5. Do you experience faecal urgency or soiling?

If the patient answers yes to 1 or more of the above and is bothered by these symptoms, it is appropriate to seek professional help or advice.

Instrumental Activities of Living (IADL) covers

- Meal preparation
- Telephone
- Managing medication
- Household chores
- Shopping
- Transport
- Financial management

Diminished performance on these tasks may signal cognitive impairment which can be subtle and difficult to detect in the early stages. For example, a person who has difficulty with using the telephone may have problems with processing information, sequencing steps of the task or dexterity problems. Again, the degree of independence or dependence for these tasks is taken into account.

Depending on each patient's presentation, CGA may also include assessments for depression, long term care, testamentary capacity, psychosocial problems and address issues of driving, nutrition, polypharmacy and elder abuse.

Useful Contact Details

Most regional geriatric services have an Aged Care Assessment Service (ACAS) and provide a range of of specialty clinics although these may vary from region to region.

- For Cognitive Dementia and Memory Service (CDAMS): www.health.vic.gov.au
- Continence Services: National Continence Helpline 1800 330 066 or the Victorian Continence Resource Centre on 03 98168266 or email cfavic@continencevictoria.org
- Falls and Balance Services (FABS): www.mednwh.unimelb.edu.au under Victorian Falls Clinic Coalition

Table 1

Mini Mental State Examination (MMSE)

Folstein et al: J Psych Res 1975: 12: 189

Max
Score


| | |
|----|--|
| | Orientation |
| 5 | What is the (Year) (Month) (Date) (Day) |
| 5 | Where are we (Country) (State) (City or Town) (Hospital) (Floor) |
| | Registration |
| 3 | Name three objects (eg ball, flag, tree) Record number of trials to learn all 3 words (Trials=) |
| | Attention and Calculation |
| 5 | Serial 7's backwards from 100. Stop after 5 answers or spell "WORLD" backwards |
| | Recall |
| 3 | Recall 3 objects from above |
| | Language |
| 2 | Name a "pencil" and a "watch" |
| 1 | Repeat the following "No ifs, and, or buts" |
| 3 | Follow a 3 stage command "Take this piece of paper in your right hand, fold it in half, and put it on the floor" |
| 1 | Read and obey the following: CLOSE YOUR EYES |
| 1 | Write a sentence |
| 1 | Copy intersecting pentagons |
| |  |
| 30 | Suggested Guidelines for determining the severity of cognitive impairment Mild: MMSE > 21 Moderate: MMSE 10-20 Severe: MMSE < 9 |

Table 2

Abbreviated Mental Test (AMT)

H.M. Hodkinson, Age and Ageing 1972: 1: 233

1. Age
 2. Time (to nearest hour)
 3. Address for recall at end of test:
"42 West Street" Patient should repeat this
 4. Year
 5. Name of the hospital/present location
 6. Recognition of 2 persons (eg doctor, nurse)
 7. Date of birth
 8. Years of the First World War
 9. Name of the current Prime Minister
 10. Count backwards from 20 to 1
- Allocate 1 point for each correct answer. A score of 7 or less is abnormal

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Rotator Cuff Disease

Douglas Li

Anatomy

The rotator cuff is composed of the short scapular muscles (supraspinatus, subscapularis, infraspinatus and teres minor) which pass under the coracoacromial arch and attach to the tuberosities of the proximal humerus. Their general function is to brace the head of the humerus to the glenoid fossa so as to give dynamic stability during shoulder active range of motion. Specifically the supraspinatus initiates abduction, subscapularis internally rotates and infraspinatus with teres minor externally rotate the shoulder.

Pathophysiology

Rotator cuff disease is a continuum of pathology starting with inflammatory changes in the subacromial bursa and rotator cuff tendons which may then progress to tendon tear and subsequent arthritis of the shoulder joint.

It primarily involves the anterior edge of the supraspinatus insertion into the greater tuberosity but more severe cases involve the remainder of the cuff and also long head of biceps.

Rotator cuff disease usually affects people over 40 years of age and are a result of repetitive microtrauma leading to wear and tear and eventual attrition. Younger patients who suffer sudden major trauma can also tear their cuff.

Stage 1 : Impingement

Impingement is the clinical entity where there is pain in the subacromial space when the shoulder is elevated and /or internally rotated. The subacromial bursa and supraspinatus tendon become entrapped between the anteroinferior edge of the acromion and coracoacromial ligament above and greater tuberosity below.



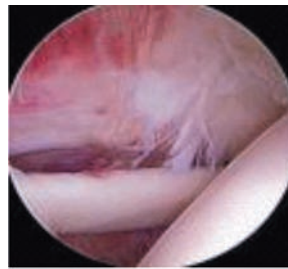
Douglas Li
Orthopaedic Surgeon

Stage 2 : Rotator cuff tendinitis

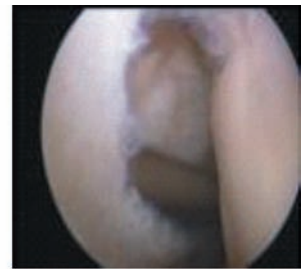
Repetitive microtrauma results in oedema and haemorrhage within the bursa and cuff, with subsequent fibrosis and tendinitis.

Stage 3 : Rotator cuff tear

Eventually the rotator cuff reaches a point of failure and tears – which may be partial or full thickness. The severity is dependent upon the tear size, amount of scarring and retraction, and chronicity of the disease.



Partial Thickness RCT



Full Thickness RCT

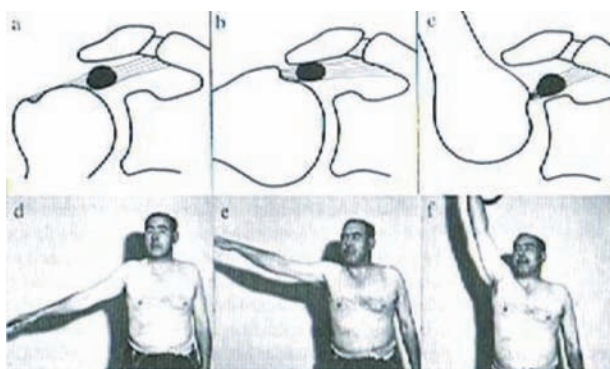
Stage 4 : Rotator cuff arthropathy

Due to the inability of the cuff to keep the humeral head in contact with the glenoid, the head migrates proximally to abut the coracoacromial arch and acromioclavicular joint and the altered forces across the glenohumeral joint results in progression to end stage osteoarthritis.

Clinical features

Patients typically complain of pain, weakness and subsequent loss of function – especially with shoulder level, overhead and behind back activities. Motion is affected with abnormal rhythm, painful arc (usually between 60 to 120 degrees of abduction) and drop arm if there is a cuff tear. Active and passive range of motion is assessed, together with strength of each of the cuff muscles. If there is a cuff tear then active motion is affected but passive range unaffected. Impingement is present if there is pain with

forward elevation and internal rotation of the shoulder. The impingement test is positive when there is abolishment of pain after a subacromial space injection of local anaesthetic and the examination is repeated.



Painful arc: The patient registers pain only over a limited arc. Diagram (b) explains the "impingement" syndrome.

Imaging

X-rays, ultrasound and MRI are helpful in evaluating the extent of the disease. Look for subacromial spurs, diminished acromio-humeral distance (normal >10mm), proximal humeral migration and sclerosis of the greater tuberosity and undersurface of acromion.



Ultrasound is 90% sensitive and specific for full thickness tears but less for partial thickness tears and is operator dependent. MRI is much more sensitive and can differentiate

partial from full thickness tears and is therefore the investigation of choice.

Natural history

If left untreated, impingement and rotator cuff tendinitis symptoms may resolve. However, recurrence often occurs and an eventual cuff tear results. Again the pain may settle, but overall function is impaired. Due to the constant traction upon the tendon and its poor blood supply, the tear will not heal spontaneously. The tear will gradually enlarge and the altered biomechanics and forces across the shoulder joint will lead to development of cuff arthropathy and osteoarthritis.

Treatment

Nonoperative treatment involves activity modification, simple analgesia, NSAIDs, physiotherapy (ROM exercises, RC strengthening, capsular stretching) and subacromial space injection (local anaesthetic and steroid). Steroid injections should be limited to a maximum of 2 as it can potentially weaken the cuff, making later repair more difficult.

Operative treatment is advised if there is no response to non operative treatment after 6-12 weeks or there is a rotator cuff tear in an active younger patient or advancement to stage 3 or 4 cuff disease is present.

Surgical treatment of rotator cuff disease involve either arthroscopic or open techniques (or a combination). The advantages of arthroscopic shoulder surgery include being minimally invasive with a faster rehabilitation. However, the technique is technically more demanding and takes twice as long. In comparison, the open method (10-12 cm incision) allows for an easier and stronger rotator cuff repair but a slower rehabilitation program.

For impingement (and partial thickness tears), an arthroscopic subacromial decompression is performed follow by excision of the bursa and resection of the coracoacromial ligament, debriding of the rotator cuff with burring of the anteroinferior acromion and AC joint osteophytes.

If there is a full thickness rotator cuff tear, the lateral portal is extended and via a mini open technique (4-5 cm inci-



Subacromial injection performed from behind

sion) the cuff is repaired with bony anchors to reattach the tendon edge to its insertion to the tuberosity.

Some rotator cuff tears are irreparable. Massive tears (>5 cm) or patients with poor bone and tissue quality or those patients unlikely to cope with the prolonged post operative rehabilitation, will be treated with arthroscopic subacromial decompression with preservation of the coracoacromial ligament (to prevent humeral head migration) with extensive debridement of the cuff and this usually provides good pain relief.

For rotator cuff arthropathy, the treatment of choice is shoulder replacement.

Rehabilitation

Length of hospital stay is 1-2 nights. For decompression alone, a sling is worn for comfort for 2-3 days only and then early active range of motion is encouraged so as to minimise the likelihood of post operative stiffness. If the rotator cuff is repaired, sling immobilisation for 4 weeks is required to allow the cuff to heal. Passive and pendular exercises only are to be performed. In the following 4 weeks active assisted exercises can be performed and thereafter a gradual active exercise program is instituted. Patients are warned that time off work following decompression surgery is approximately 4 weeks. After cuff repair light duties may only commence after 8-12 weeks and heavy duties after 16-20 weeks.

Risks of surgery

Patients are to be counselled as to their diagnosis and natural history and if surgery is proposed what the pertinent risks are. In addition to the usual risks of anaesthesia and surgery, specific risks include infection, neurovascular injury, post operative adhesive capsulitis, failed repair or recurrence of tear, reflex sympathetic dystrophy/chronic pain and incomplete resolution of pain due to background osteoarthritis.

Results of surgery

Recovery is a slow process, and the full benefits of surgery may not be felt until 4-6 months after decompression surgery and following cuff repair, up to 12 months. Overall, the majority of patients find relief from pain and improved shoulder function.

Alzheimer's disease

Walter Gee

Alzheimer's disease is named after Alois Alzheimer who first described the typical neurofibrillary tangles seen in the central nervous system in 1907. As the average life expectancy in the Western World has increased during the past century so has the prevalence of Alzheimer's disease. It's currently estimated that in Australia there are approximately 110,000 people suffering from Alzheimer's disease. By the year 2040 this figure is expected to rise to 500,000. The prevalence of dementia (the most common form of which is Alzheimer's disease) has increased more than 60% in the past decade. The direct health cost of dementia last year was over 3 billion dollars

At the moment there is only one class of drug approved on the PBS for the symptomatic treatment of Alzheimer's disease. These are the cholinesterase inhibitors. In Alzheimer's disease there is a presynaptic deficit of the neurotransmitter acetyl choline. These drugs inhibit the enzyme acetylcholinesterase that normally breaks down the acetylcholine released into the synapse. This prolongs the half life of the acetylcholine and improves cholinergic transmission. The three drugs available in Australia are *donepezil* (Aricept), *galantamine* (Reminyl) and *rivastigmine* (Exelon). Galantamine also has an effect on nicotinic neurotransmission. These drugs are approved for the treatment of mild to moderately advanced Alzheimer's disease. Their effect is to slow down the progression of the disease. Unfortunately they are not effective in all patients.

The drug *memantine* (Ebixa) has been available in Australia for almost two years now. Despite efforts by its manufacturer to a listing it is not available on the PBS and is only available by private prescription. It works via a different neurotransmitter pathway than the cholinesterase inhibitors.

In Alzheimer's disease there is a known decrease in glutamatergic neurones, synapses and receptors. Lack of receptors results in a relatively elevated concentration

of glutamate in the synaptic cleft. The increased glutamate displaces Mg ions from NMDA receptor channels leading to a prolonged influx of calcium into the neuron. Chronically elevated postsynaptic calcium levels results in chronic excitation of the neuron which can lead to it's eventual death. Memantine (Ebixa) binds to and blocks the NMDA receptor in this situation. It is only displaced when there is quite high concentration of glutamate in the synapses as occurs during a normal memory signal. Memantine thus is regarded as being neuroprotective. It is being marketed for the treatment of moderate to severely advanced Alzheimer's disease.

In the middle of 2004 the National Institute of Ageing in North America launched a clinical trial of *huperzine A* as a treatment of mild to moderately advanced Alzheimer's disease. Huperzine is a herbal supplement derived from the plant *Huperzia serrata* which has been used for centuries in traditional Chinese medicine in the treatment of swelling, fever and blood disorders. Recent trials in China have shown some benefit of huperzine A in Alzheimer's disease. It is interesting to note that galantamine although now synthetically produced, was originally derived from the snowdrop flower *Galanthus nivalis*. Research suggests that huperzine A may have similar mode of action as the cholinesterase inhibitors, that it has a neuroprotective effect.

A great deal of interest lately has focussed on the amyloid plaque which is one of the main histopathological features of Alzheimer's disease. These develop when amyloid-beta peptide, especially the 42 amino-acid form, is deposited as extracellular accumulations in the brain. In the normal situation, an enzyme called alpha secretase cleaves amyloid precursor protein (APP) forming soluble APP alpha which is excreted from the central nervous system. However two other enzymes (beta secretase and gamma secretase) can also cleave the APP at two different points leading to two fragments: a shorter soluble excretable APP beta molecule and an amyloid beta fragment which has a fibrillar form



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that aggregates into insoluble plaques. It is amyloid beta peptide which is thought to be pathological. The amyloid beta peptide itself may have direct neurotoxic effects. The amyloid plaques that result may cause both oxidative and inflammatory damage to the neurones.

The amyloid hypothesis as the main cause of Alzheimer's disease is supported by the following evidence:

- 1) There are a few hundred family cohorts worldwide where family members who carry certain rare genes will nearly all develop Alzheimer's disease. All of these genes increase production or accumulation of beta amyloid.
- 2) Mice have been genetically modified to carry some of the genes associated with these rare familial forms of Alzheimer's disease. These mice develop amyloid plaques and display cognitive impairment.
- 3) Individuals with Down's Syndrome usually have trisomy of chromosome 14 and so have three copies of the APP gene instead of the usual two. By the time they reach middle age nearly all these people have developed excessive amyloid plaques and Alzheimer's disease.

It should be noted that not all researchers and experts are convinced that accumulation of beta amyloid is the main cause of Alzheimer's disease.

There is experimental data that transgenic mice are immunised with a "vaccine" containing beta amyloid then the accumulation of amyloid plaques that normally occurs can be arrested. Unfortunately human trials with a vaccine developed from this research had to be ceased prematurely due to the alarming occurrence of serious brain inflammation in the recipients. Another strategy is to administer laboratory-produced antibodies rather than relying upon the activation of the patients immune system. A number

of pharmaceutical companies are developing genetically engineered anti-beta-amyloid antibodies which are yet to be trialled.

Another possible therapeutic approach may be to prevent the beta-amyloid fragments from sticking together. Drugs in this class are called "anti-aggregants". The first large, phase 3 clinical trial of an anti-aggregant (Alzhemed) commenced in August 2004. Alzhemed is designed to prevent the first stages of beta-amyloid accumulation and to promote clearance of amyloid fragments from the brain.

It has been difficult to quantify the amount of amyloid in the brain of sufferers of Alzheimer's disease. Indeed if the amyloid hypothesis of Alzheimer's disease is to be proven true then there has to be some means of measuring the amount of amyloid in the brain before and after treatment to see if cessation of amyloid plaque accumulation is correlated with a cessation of the usual cognitive decline seen in Alzheimer's disease. Researchers at the University of Pittsburgh have recently developed a compound known as Pittsburgh Compound-B (PIB) which attaches to amyloid plaques in the central nervous system. This bound PIB is then detectable by imaging with a PET scanner. This technique will allow investigators to determine the efficacy of anti-amyloid drugs by non-invasive means, thus avoiding a brain biopsy.

A considerable amount of research is being undertaken in the area of Alzheimer's disease. The hope is that new therapies will be able to arrest the progression of the disease. There is even research at the moment which may eventually lead to some degree of neuronal regeneration in the brain. As the population ages and the prevalence of Alzheimer's disease rises the future may not be so bleak.

Snoring and the honey moon period

Matthew T. Naughton

The honeymoon period of interest for “snoring and sleep apnoea” is just beginning with respiratory physicians, allergists, dentists, ear nose and throat surgeons, bariatric surgeons, dieticians, psychiatrists, physiologists and industry part of the party!

Whether to take snoring seriously or not depends on the health professional’s exposure to the problem. For someone who is not exposed personally to the noise and has interests in other fields (eg nephrology or podiatry), they may be disrespectful of the agony loud snoring creates to a partner’s ability to sleep. In contrast, the spouse of a snorer, or a health care provider involved in the field will take a completely different view to snoring.

In my opinion, there are three major reasons to take snoring seriously.

First is noise. A spouse whose sleep has been fragmented by noises in excess of that experienced standing beside a jack hammer in full flight will attend your clinic with desperation searching for a cure and a peaceful nights sleep. Strong evidence exists that sleep loss is associated with impaired judgement, mental and physical dexterity, altered personality (depression), impaired capacity to take on new information, impaired glucose tolerance, impaired response to vaccination and even systemic hypertension! Snoring itself will fragment the sleep of the snorer as well, and result in impaired higher mental function as indicated by the lower grade scores at primary school and university in habitual snorers compared with non-snorers. Is this not an important indication to take snoring seriously?

Second is cardiovascular risk. Significant evidence links snoring and sleep apnoea with cardiovascular risk. Patients with moderate to severe obstructive sleep apnoea who are left untreated for 12 years have a significantly greater chance



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of fatal and non fatal cardiovascular events compared with treated control subjects. When sleep apnoea is created artificially in animals, systemic hypertension develops. Humans with sleep apnoea and hypertension have greater sympathetic activity awake and asleep, reduced vagal activity, reset baroreceptor function and impaired endothelial function (eg nitric oxide release). Children and adults with untreated sleep apnoea develop left ventricular hypertrophy and, if left untreated long enough, impaired systolic contraction. Clearly the “well known” cardiovascular risk factors such as smoking, male gender, obesity, diabetes and age overlap with risk factors for sleep apnea. However, large (>6000 participants) studies suggest that sleep apnea is an independent risk factor for the development of cardiovascular disease.

Third is sleepiness. Inattention and sleepiness is common within the community at large and within the snoring community. Many factors contribute to sleepiness, including sleep deprivation, depression, medication side effects and are frequently difficult to tease apart. Importantly however, are “hidden” reversible factors such as sleep apnea, and the associated sleep fragmentation and deprivation.

What measures should be undertaken to manage the snorer? Initial assessment of the snoring should include history and examination (table 1&3). Confirmation of diagnosis is important and usually requires referral to a sleep centre for a test. Depending on the history and examination findings, a pretest probability can be set. Based upon this pre-test probability, a test can be performed to confirm or refute the diagnosis. A detailed polysomnogram can assist in deciding whether snoring is occurring in relation to (a) body position, (b) sleep stage, (c) nasal obstruction. Alternative diagnostic strategies such as home oximetry or cardiopulmonary studies are likely to become more popular but at present sensitivity, specificity are limited and funding for such studies do not exist.

Treatments for snoring fall into 4 categories: Lifestyle change, continuous positive airway pressure, mandibular advancement splints and surgery. The former is the most effective in the mild to moderate patient and can be activated by anyone and is how I would like to focus the rest of this article.

Lifestyle change encompasses the following (table 2):

1. Good sleep hygiene: avoiding sleep deprivation, excessive medications which alter sleep (sedatives, stimulants), treating underlying psychological or psychiatric disorders, regular exercise and sensible eating habits, patients should sleep in cool, dark and quiet environments. A bedtime ritual such as reading is an excellent way to promote sleep.
2. Weight loss: various techniques are available and one should use which ever works. In addition to exercise and the quality and quantity of food intake, the timing of food intake is crucial. As a guide, we should have carbohydrate in the mornings and lunch, and protein at lunch and evenings and minimize fats across the day. Meal size should be greatest in the morning, smaller at lunch, and smallest in the evening. More elaborate measures to lose weight should be undertaken under close guidance (eg medications, Optifast diets, surgery etc)
3. Alcohol: I'm afraid I am not convinced of the "life extending" properties of alcohol when taken at night. The large long term studies (Thun et al, NEJM) do not convince me. I know that alcohol will make a large proportion of our community snore, and as such increase their risk of sleep apnea and the associated cardiovascular complications. My advice: "cautious alcohol intake and confined to special occasions rather than for medicinal purposes (replace with cooked tomatoes!)."
4. Cigarettes: these are known to increase nasal resistance, promote oral breathing at night and as such predispose to snoring. Good supportive data exists in the scientific literature.
5. Reduce nasal resistance: do so in what ever way possible. This may include the treatment of allergic rhinitis

or sinusitis, nasal steroids, smoking cessation, "Breathe Right strips" or possibly surgery.

6. Alter sleeping position: avoidance of the supine position is paramount in most snorers. The best position to sleep is in the recovery position, ideally with left hand side down to reduce any chance of gastroesophageal reflux. One study showed that sewing a tennis ball into the pyjamas of patients (to avoid supine sleep) with snoring and hypertension resulted in a fall in 24 hours systemic blood pressure! Jaw position may alter with or without dentures: patients should be asked to experiment as to whether to sleep with them in or out.

7. Reduce or avoid medications which might aggravate snoring: these include sedatives, analgesics, glucocorticoids, antiepileptics.

8. Ensure that the innocent intermittent otherwise healthy snorer is not being blamed for poor sleep in the insomniac or psychologically disturbed bed partner. Obviously what is the chicken and what is the egg can be difficult to discern.

When the above measures have been considered, sleep specialist referral should be considered at which time appropriate investigation and management can be discussed with the patient.

Fig 1. The Mallampati Index

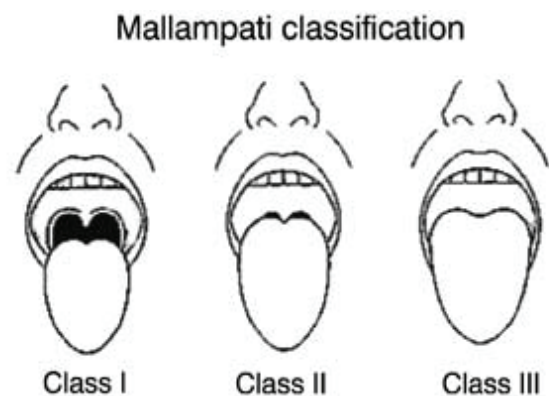


Table 1. Assessment of snoring

Mild:

snores <3 nights per week
 no witnessed apnoeas
 bed partner not disturbed
 no established cardiovascular risk factors
 absence of sleepiness
 no physical abnormalities

ACTION:

lifestyle modification

Moderate:

snores most nights
 snores only in supine position
 snoring wakes bed partner, but sleeps in same room
 Sleepiness at times permitted
 No established cardiovascular risk factors
 Blood pressure upper limit of normal

ACTION:

Lifestyle modification
 Consider Mandibular advancement splint
 Consider CPAP
 Consider Upper airway surgery if surgical resectable lesion

Severe:

snores most nights
 partner sleeps separately
 witnessed apnoeas
 cardiovascular risks
 Sleepiness at any time

ACTION:

Lifestyle modification and CPAP.

Table 2. Lifestyle modification

cautious alcohol consumption
 cease cigarettes
 weight loss
 sleep on side (recovery position)
 maintain nasal patency
 treat/prevent sinusitis
 avoid sleep deprivation and overnight shift work

Table 3. Upper airway examination

Teeth: health, number, plates, bridges etc.
 Mouth opening size
 Mallampati score
 Jaw position
 Body mass Index
 Neck circumference
 Nasal patency
 Maxillary position

New Advances in the Diagnosis, Treatment and Prevention of Malaria

Allen Cheng

Malaria remains one of the world's great killers. It is estimated that over a million deaths occur each year worldwide; although most occur in African children, significant problems remain in South East Asia. Increasing rates of drug resistance are complicating efforts to reduce mortality from malaria. In Australia, almost all malaria is imported; fever in a traveller returning from an endemic region should prompt a search for malaria. It should be noted that patients with malaria not uncommonly have symptoms that suggest an alternative diagnosis, such as a cough or diarrhoea.

Diagnostics

Thick and thin blood films remain the gold standard for the diagnosis of malaria. Three consecutive film examinations are required to exclude malaria. Increasingly, pathology laboratories are using rapid tests for the malarial antigens, *parasitic lactate dehydrogenase* (pLDH; OptiMAL, Flow Inc) or *histidine-rich protein 2* (HRP-2). The older tests (Parasight-F, ICT Malaria Pf and PATH Falciparum Malaria IC Strip) detect *P. falciparum* only but newer assays (OptiMAL assay, and the ICT Malaria Pf/Pv assay) can detect both *P. falciparum* and *P. vivax*. These tests have good sensitivity (88-95%) and specificity (89-99%) for *P. falciparum* infection when compared to microscopy in the hands of an experienced technician (1).

A common problem is that of a positive antigen test in the absence of visible parasites on film. This may represent one of four clinical possibilities; low level parasitaemia below the threshold for detection by microscopy, residual antigenaemia following successful treatment (for up to 28 days), a biological false positive (sometimes seen with rheumatoid arthritis) or an incorrect interpretation of the assay. In the absence of a history of treatment, any patient with positive antigen assays but negative films should be managed as having malaria infection.

Molecular tests for DNA of *Plasmodium* spp remain a research tool. Detection of an anti-malarial antibody is evidence of past exposure and is only used in the screening of blood donors.

Treatment

Malaria due to Plasmodium falciparum

Falciparum malaria is a medical emergency and requires immediate treatment in hospital. Patients may deteriorate rapidly; severe malaria is characterized any of the following: altered consciousness, jaundice, oliguria, severe anaemia, acidosis or hypoglycaemia, or a parasite count above 100,000/mm³ (>2% of red blood cells). Severe malaria requires intravenous therapy, but many patients with uncomplicated falciparum malaria may be treated with oral quinine or other drugs. There is increasing recognition that supportive measures, such as adequate fluid resuscitation, correction of electrolyte abnormalities and respiratory support, are crucial to outcome (2).

A major advance in the treatment of malaria has been the re-discovery of a new class of drugs derived from *Artemisia annua* or qinghaosu. This herb, also known as sweet wormwood, was used for a variety of conditions in traditional Chinese medicine. Research performed in China in the late 1960s examined the efficacy of approximately two hundred traditional remedies; only qinghaosu was demonstrated to be effective. Much of this literature remained unknown outside China for many years, but eventually its significance was recognized internationally. From this herb, two drugs have been isolated, Artemether and Artesunate.

Although many smaller trials have suggested a mortality benefit when compared to quinine, a recent large trial in south east Asia has demonstrated its superiority (3). A major problem that remains is the complex manufacturing process involved; current intravenous preparations of

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Artesunate do not yet meet Good Manufacturing Practice standards, but it is hoped that this problem will be overcome soon. Because of this, Artesunate is not yet licensed for use in Australia and many other countries. A rectal preparation of Artesunate is also being evaluated and may be useful for children without access to hospital care in resource-poor locations such as in many African countries (4). A synthetic *artemisinin*, OZ-277, has recently been developed; an early trial of this drug has recently concluded in Thailand (5).

Quinine, or its closely related isomer quinidine, remains the standard for treatment of severe malaria in Australia. An increasingly encountered problem is the availability of these drugs, particularly as other anti-arrhythmic drugs have replaced intravenous quinidine in hospitals. Most hospitals have reserved some limited stock of intravenous quinine for this indication. Intravenous quinine has a narrow therapeutic window; cardiac monitoring together with careful observation of blood pressure and blood glucose is required.

Alternative drugs are available for patients with non-severe falciparum malaria that are able to tolerate oral medications, including Mefloquine, Atovaquone and Artemether-lumefantrine (Riamet, Novartis). A common error is failing to adjust for the formulation of quinine; 100 mg quinine anhydrous base is equivalent to quinine bisulfate 169 mg, quinine dihydrochloride 122 mg, quinine hydrochloride 122 mg or quinine sulfate 121 mg.

In endemic regions, resistance to many commonly used antimalarials has developed. Most significantly this has included Mefloquine in the Thai-Burma and Thai-Cambodia border regions, and to Pyrimethamine+sulfadoxine (Fansidar) in most parts of Africa. In an effort to protect the remaining active drugs, Artesmesinin combination therapies (ACT) are now recommended by the World Health Organization. Unfortunately, the price of ACT is prohibitive for many countries (US1.50-\$2.40 for adults), and shortages in supply have exacerbated the situation. Travellers should be aware that counterfeit antimalarial drugs are common in many countries (6).

Malaria due to Plasmodium vivax and other species

Plasmodium vivax, *P. malariae* and *P. ovale* are generally milder infections. In most regions, Chloroquine remains

effective but hypnozoites may remain in the liver and cause relapse. For patients not resident in endemic areas, an eradication course of Primaquine is usually recommended following infection with *P. vivax* and *P. ovale*. Primaquine may be associated with severe haemolysis in patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency.

Studies have demonstrated very high rates of resistance in *P. vivax* in West Papua (formerly Irian Jaya) in Indonesia and Papua New Guinea (7). Alternative agents include Mefloquine, Atovaquone/Proguanil or Quinine.

Prevention

The prevention of bites by *anopheline* mosquitoes that transmit malaria cannot be overstated. This includes the use of DEET-containing insect repellent, the wearing of light-coloured long trousers and long-sleeved shirts in the evening, sleeping in screened accommodation or using pyrethrin-impregnated mosquito nets, avoidance of outside activities between dusk and dawn and the avoidance of perfume and aftershave.

The combination of Atovaquone and Proguanil (Malarone, GlaxoSmithKline) has recently been introduced for prophylaxis against malaria. Other commonly used regimens include Doxycycline or Mefloquine. A common perception is that Mefloquine is associated with neuropsychiatric complications, but studies indicate that the incidence of significant problems is low (8). A combination of Chloroquine and Proguanil is not commonly used due to significant rates of resistance and clinical failure, but may be appropriate in pregnant women and in certain regions.

Other agents being developed for prophylaxis include Tafenoquine, a long acting drug closely related to Primaquine (9). Primaquine may also be used for prophylaxis but is associated with significant toxicity and intolerance.

Summary

Falciparum malaria is a medical emergency. Rapid tests for malarial antigens are being increasingly used in Australia in addition to microscopy.

For malaria due to *P. falciparum*, resistance is emerging in endemic regions. Artesunate is now recognized as the best treatment in adults with severe malaria, but is not yet available in Australia. Artemisinin combination therapies are

now recommended in most endemic regions. For malaria due to other species, resistance to chloroquine is uncommon except in specific areas.

Many regimens are available for chemoprophylaxis. The combination of Atovaquone and Proguanil has been introduced and joins Doxycycline and Mefloquine as first line regimens for the prevention of malaria in travellers.

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- * Source: O'Brien D, Biggs B. Malaria prevention in the expatriate and long-term traveller. *Aust Prescr* 2002;25(3):66

Table 1: Drugs for treatment of malaria in Australia

| Severe malaria | Uncomplicated <i>P. falciparum</i> malaria | Malaria due to other species |
|---|--|---|
| <p>Quinine dihydrochloride 7mg/kg in 500mL IV over 30 minutes^a; then</p> <p>Quinine dihydrochloride 10mg/kg in 700mL IV over 4 hours^a; then</p> <p>Quinine dihydrochloride 10mg/kg in 700mL IV over 4 hours, every 8 hours</p> <p>Cardiac monitoring and frequent monitoring of blood pressure and serum glucose are required</p> <p>^a No loading dose if patient has received quinine, chloroquine or mefloquine in the previous 48 hours</p> | <p>Quinine sulfate (child: 10 mg/kg up to) 600 mg (adult <50 kg: 450 mg) orally, 8-hourly for 7 days</p> <p>PLUS EITHER</p> <p>Doxycycline (child >8 years: 2 mg/kg up to) 100 mg orally, 12-hourly for 7 days</p> <p>OR</p> <p>Pyrimethamine+sulfadoxine^b 25+500 mg (child 6 weeks to <1 year: 1/4 tablet; 1 to 3 years: 1/2 tablet; 4 to 8 years: 1 tablet; 9 to 14 years: 2 tablets) adult: 3 tablets (=75+1500 mg) orally, as a single dose on day 3 or 4 of the oral quinine treatment.</p> <p>Alternatives for patients not unwell^c:</p> <ul style="list-style-type: none"> • Atovaquone+proguanil • Mefloquine • Artemether+lumefantrine <p>^b for malaria NOT acquired in South-East Asia</p> <p>^c Check guidelines for dosing</p> | <p>Chloroquine ^d (child: 10 mg base/kg up to) 620 mg base (=4 tablets) orally, initially</p> <p>THEN (child: 5 mg base/kg up to) 310 mg (=2 tablets) 6 hours later and on days 2 and 3.</p> <p>THEN Primaquine^e (see guidelines for dosing)</p> <p>^d Resistance described in vivax malaria acquired in PNG/W Papua</p> <p>^e exclude G6PD deficiency prior to administration</p> |

Table 2: Drugs for prophylaxis of malaria in Australia

| Medication | Adult dose | Frequency | Pregnancy | Children |
|--------------------------|----------------|-----------------|------------|------------------|
| Chloroquine Proguanil | 300mg 200mg | weekly daily | Yes Yes | Yes Yes |
| Doxycycline | 100mg | daily | No | 8 years or older |
| Mefloquine | 250mg | weekly | No† | >5kg |
| Atovaquone/proguanil | 250mg/100mg | daily | No | >11kg |

* Source: O'Brien D, Biggs B. Malaria prevention in the expatriate and long-term traveller. Aust Prescr 2002;25(3):66-9.

Faecal Examination - a Holistic Approach

C K Foo
Colin Taylor

A Report on 138 Stools Analysis (a limited study) in General Practice in Melbourne, Australia.

138 stool specimens from 119 patients were examined over a period of two months (from January 31st to March 30th 2000) in a general practice setting. The stools were examined macroscopically for obvious abnormality; microscopically for parasites, yeast, starch cells, vegetable fibres, fat, meat fibres and lactobacilli; culture and sensitivity were performed. 37 (31%) had gastrointestinal symptoms while 82 had no GIT symptoms.

Findings:

Abnormal findings were found in 47.4% of the specimens by macroscopic examination and 66.6% by microscopic examination. Abnormal gut flora was found in 85% of the culture with 26% of the specimens grew *Candida* Species and <1% grew pathogenic organism. Cysts & ova from parasites were identified in <1% of the specimens. 34% revealed inadequate or absence of lactobacillus in the stool samples.

The abnormal organisms found (43% of the specimens) were:

| | |
|---|----------|
| <i>Klebsiella Aerogenes</i> | 41 cases |
| <i>Candida Albicans/Candida species</i> | 37 cases |
| <i>Enterobacter species</i> | 7 cases |
| <i>Pseudomonas aerogenes</i> | 1 case |

General Observation:

The two most common causes of abnormal gut flora were:

- 1) Over generous use of broad-spectrum antibiotics
- 2) Over zealous use of detergents in cooking & eating utensils washing.

Patients with gastrointestinal problems showed a higher incidence of abnormal findings including the presence of abnormal gut flora and digestive dysfunction. This group of patients responded very well to dietary, lifestyle changes and Pro-biotic supplementation. In the non-GIT patients there were no obvious correlation between the type of organism in the stools and the medical condition. A larger study using comprehensive digestive stool analysis is recommended, using one medical condition for study (e.g. rheumatoid arthritis, ulcerative colitis, and Crohn's disease patients).

(Paper presented at the 4th World Congress of Medical Acupuncture and Natural Medicine, Edmonton, Alberta, Canada, August 23-27, 2000)

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The Role of Insulin in The Management of Type II Diabetes

Sylvia Lim Tio

Insulin management in type II diabetes

The frequency of type II diabetes is increasing worldwide, including that in childhood and young adulthood. The earlier onset of type II diabetes may result in increased duration of diabetes and lifetime risk of complications, an increased incidence of type II diabetes in pregnancy. There is greater benefits with intensive management.

Therapeutic options in type II Diabetes include diet alone, sulphonylureas, metformin, glitazones, glucosidase inhibitors and insulin. While many patients can be optimally managed with a combination of diet and/or oral hypoglycaemic agents, up to 25% of patients may require the addition of insulin to optimise their diabetes management.

This review will focus on the role of insulin in the management of patients previously known to have type II diabetes.

Patient selection and therapeutic targets

Insulin should be considered in the following groups:

- (i) To improve glycaemic control
 - (a) Acute Illness
 - (b) Chronic-suboptimal glycaemic control despite maximal doses of oral agents
- (ii) Beta cell failure
- (iii) Oral agents contraindicated eg hepatic failure, renal failure, pregnancy, breast feeding
- (iv) Pregnancy/preconception

Improving Glycaemic Levels

Several large scale clinical trials have demonstrated that maintaining desirable glucose levels or as near as possible, decreases both early microvascular complications and late macrovascular complications. In patients with Type I diabetes, intensive insulin therapy resulted in a reduction of the adjusted mean risk of the development of new retinopathy by 76%; slowed the progression of retinopathy by 54%; reduced the occurrence of clinical neuropathy

by 60% and albuminuria by 50% (1). In type II diabetes, better glycaemic control significantly decreased the risk of microvascular complications by 12% (2a). There was also a trend to decreased macrovascular complications and this difference has subsequently been shown to be statistically significant with longer follow up (2b).

In critically ill intensive care patients, intensive insulin therapy halved organ failure and mortality rates from 8% to 4.2% (3). An initial pilot study in acute myocardial infarction (4) also showed an improvement in cardiac outcomes but this was not subsequently confirmed in a later study-possibly because the glycaemic control was similar in both the conventional and intensively treated arms due to stricter therapeutic targets in conventional medicine. Intensive insulin therapy in critically ill patients has an anti-inflammatory effect, improves hepatic ultrastructure and function, and lowers circulating levels of ICAM1, iNOS gene expression and NF κ B (Nuclear factor kappa β) activation, which may result in improved endothelial protection (4).

The American Diabetes Association recommends that HbA1C levels be lowered to <7%; fasting levels between 5-7.2mmol/l and 2 hour postprandial levels <10mmol/l (6a). The American College of Endocrinology recommends even stricter guidelines (HbA1C <6.5%) and more intensive treatment should be considered for high risk patients, if it is possible to achieve this without excessive hypoglycemia (6b). However, treatment strategies and aims will need to be individualised for each patient.

Patients with Type II diabetes may be able to be managed with diet and oral hypoglycaemic agents alone. However up to 25% of patients in the UKPDS (United Kingdom Prevention of Diabetes Study) had to be switched to insulin treatment within 6 years because of lack of efficacy of the oral agents in maintaining good glycaemic control (7).

Beta Cell Failure

Several defects exist in type II Diabetes:

- Defects in insulin signalling causing insulin resistance
- Defects in insulin secretion causing hypoinsulinemia
- Apoptosis causing beta cell failure and further decreases in insulin secretion.

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The development of significant beta cell failure and decreased insulin secretion in type II Diabetes may result from;

- Progressive beta cell exhaustion, particularly in patients with longer duration of diabetes or poorly controlled diabetes
- Latent autoimmune diabetes in adult (LADA), where the progression of autoimmune pancreatic failure is relatively slow and patients may initially be able to managed with oral hypoglycaemic agents alone for up to a few years. The presence of GAD (Glutamic Acid Decarboxylase) antibodies predicts the likelihood of progression to beta cell loss and the absolute need for insulin treatment and risk of ketosis and should be measured in lean patients with apparent “Type II diabetes”
- Destruction of the pancreas eg carcinoma of the pancreas, pancreatitis

Patients with decreased beta cell reserve and decreased insulin secretion often present with weight loss and are prone to ketosis. Beta cell failure should be considered in lean patients and fasting C peptide levels/GAD antibodies measured.

Key management issues in these patients include

- the absolute need for insulin and the risk of ketosis of insulin injections are missed, hence the need for ongoing insulin (with a dextrose drip if required) even if fasting or unable to tolerate oral fluids for other reasons
- sick day management and the risk of ketoacidosis
- Basal bolus insulin is often required to optimise insulin control.

Pregnancy

The incidence of adverse maternal and perinatal outcomes in patients with type II diabetes exceeds that of the background population and is at least as high, if not greater, than in type I diabetes (8,9,10). These include increased rates of perinatal mortality (2.5-7%), serious congenital malformations (6.6-9.9%) such as cardiac malformations, anencephaly; preterm deliveries, fetal loss before 24 weeks, macrosomia (up to 50%), IUGR (Intrauterine Growth Retardation), jaundice, pregnancy induced hypertension (10%) and preeclampsia (7%).

The rate of complications, including perinatal mortality and serious malformations is at least as high as, and in

some studies, exceeds that of type I diabetes by up to 2-3 fold (9,10). Poor outcome is associated with poorer metabolic control, including first trimester control, to HbA1C levels of <7%.

Ideally, patients with type II diabetes should aim to:

- optimise glycaemic control prior to pregnancy
- Cessation of oral hypoglycaemic agents and commencement of insulin if required preconception and as early as required during pregnancy, including first trimester
- Intensive monitoring of BGLs (Blood Glucose Levels) preconception and during pregnancy
- HbA1C at least <7%, and if possible to <6% while avoiding hypoglycaemic episodes;
- fasting glucose levels of <5.5 mmol/l, post partum glucose levels of <7mmol/l (11)
- Screen for and treat other potential complications (eg retinopathy) prior to conception and monitor during pregnancy
- cease potentially teratogenic agents prior to pregnancy. Commence folate 5mg daily.
- refer to endocrinologist for preconception planning and early review during pregnancy/early obstetric referral during pregnancy

Insulin Regimes

Insulin regimes include:

1. bd premixed insulins
Mixtard 20/80, 30/70, 50/50 (Actrapid and protaphane in varying mixtures)
Humalog mix 25 (Lispro 25%, Neutral protamine lispro 75%)
Novomix (Aspart 25% Protaphane 75%)
2. bd intermediate acting insulins (eg protaphane /NPH)
3. Nocte protaphane/NPH
4. Once daily long acting insulin (lantus or detemir).
5. Basal bolus insulin
6. Insulin pump

The most common insulin regime for initiation in patents with type II diabetes is that of a twice daily premixed regime, with differing combinations of short and intermediate acting insulins. These regimes are more successful in lowering post prandial glycaemic levels than that of intermediate or long acting insulin alone. Nocte intermediate acting insulins may be used where the aim is solely to

lower fasting glucose levels but are not usually sufficient to improve postprandial glucose levels. The newer long acting insulin analogues (*detemir* and *glargine*) have a longer duration of action and reduced day to day variability relative to intermediate acting human insulins but are also usually less effective than a combination of long and short acting insulins to improve glycemic levels. Glargine binds to the IGF1 receptor with high affinity as well as to insulin receptor. Potential long term effects on cellular growth, proliferation and CV outcomes (including potential adverse effects) have still to be determined.

Basal bolus insulin may be required in patients where more intensive management is required, eg patients with beta cell exhaustion or in preconception/pregnancy. This is usually a combination of bolus meal time insulin (a short acting insulin ie Novorapid/Humalog/Actrapid) and longer acting basal insulin (either intermediate acting eg NPH/Protaphane twice a day or long acting eg Lantus/Detemir once or twice a day). Lantus and Detemir may be particularly useful in reducing overnight hypoglycaemic episodes for patients with recurrent overnight hypoglycemia with intermediate acting insulin, which in turn limits improvements in glycemic control. There is limited information on the safety of insulin analogues in pregnancy. *Glargine* and *detemir* are contraindicated, at least for the time being, in pregnancy (11).

50-70% of insulin requirements are usually given as the basal insulin and the remainder as bolus doses with meals. When twice daily regimes are used, the bolus/basal ratio is premixed and a 30/70 combination is the usual initiating regime. Titrate insulin dose by smaller increments (1-2Units, even smaller dose changes may be required in children) in insulin sensitive patients with type I diabetes. Larger increments may be required in insulin resistant patients (commence changes with 2-4 Unit increments initially).

Dietary intervention and education are integral parts of optimisation of care. Therapy should be selected and optimised on a case-by-case basis.

Summary

- Intensive glucose optimisation reduces complications and may require insulin. Aim for HbA1C < 7%, < 6-6.5% in high risk patients or pre-conception/pregnancy
- Beta cell failure should be considered in lean patients. Insulin treatment will be required if confirmed.
- Identify patients who are “insulin resistant” versus “insulin sensitive”
- Insulin requiring versus beta cell exhaustion (insulin dependent) as these result in key differences in management.

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HPV Vaccination

Michael Quinn

Vaccinating against HPV – is it the whole answer to the cancer of the cervix?

More than 500,000 new cases of Cancer of the Cervix are diagnosed annually, with 80% of these being in the developed world, where the vast majority of women receive no treatment. The recent publication of seminal articles showing almost complete protection against persistent Human Papilloma Virus (HPV) infection and the development of cervical dysplasia, has led to a wave of optimism across the health care sector, but this article will endeavour to give a true perspective of the situation and highlight areas that need addressing, particularly in Australia, before a successful program for HPV vaccine introduction can be instituted.

Worldwide incidence of cervical cancer

The overall lifetime risk of a woman getting cancer of the cervix globally is 3-4%. In North America it is not one of the top 7 cancers, both in incidence and mortality, whilst in Europe it is number 4 on the incidence list and number 7 on the mortality list. This is largely due to a lack of screening in Eastern Europe. In contrast, cervical cancer is the second most common cancer in women in Central and South America and the second most common cause of death. In Africa it is the most common cancer, with the highest mortality.

In our own region of Asia, carcinoma of the cervix is the second most common cancer, but the fourth cause of cancer death, testifying to some success in various treatment programmes.

This global incidence of cancer of the cervix is directly related to infection with high risk human papilloma virus sub types, particularly HPV 16 and 18, with the peak of infection occurring between the ages of 20 and 25 and then an exponential drop off until the age of 60, where there is a small rise once more. This pattern is seen across the five continents.

Michael Quinn

Consultant Obstetrician & Gynaecologist

Within any one area however, there are marked disparities in HPV sub type prevalence rates. For instance the prevalence rate in India is ten times that in Thailand, and the lowest prevalence rate is in North Vietnam. We are unable to comment on Australian prevalence rates, since data is not available.

HPV type 16 and 18 account for almost 70% of all cervical cancers globally, but there is regional variation; for example the next most common sub type is HPV 31 associated with cervix cancer in Central and South America, whereas HPV 45 is the most common sub types in all other areas apart from Japan where HPV 52 has this distinction.

There are only two vaccine types currently about to be licensed, the first being a quadrivalent vaccine of HPV 16, 18, 6 and 11, to protect against both cervix cancer and genital warts, and the second being against HPV 16 and 18 only.

Both vaccines have shown to reduce the incidence of persistent infection and subsequent cervical dysplasia with no serious adverse events. The bivalent vaccine interestingly has shown some cross protection against HPV types 31, 45 and 52.

Implementation issues

The question as to whether both boys and girls should be vaccinated and at what age still has not been resolved. Certainly the quadrivalent vaccine should give some protection against genital warts in males.

Also the need to booster following the initial three vaccinations is still unclear and long term data is going to be required to answer the question.

The effect on current screening programmes still has to be worked out, but it should be noted that Pap smear screening without vaccination would prevent more cervical cancer

deaths than HPV 16/18 vaccination without Pap screening. Note the less it can be predicted the pre-pubertal vaccination may lead to a later age at first Pap smear and also a reduction in the frequency of screening, which in turn would lead to substantial savings. However, on the other hand, some women may no longer feel a need for Pap tests since there may be misconceptions on how complete protection will be.

The question as to whether adult women should also receive vaccine against HPV subtypes 16 and 18 is also controversial. There are certainly no indications at present that these vaccines are less safe in women who have had or currently have HPV infections and it would be difficult to deny these women a safe vaccine, even if vaccination did nothing for the current infection, as new infections could be prevented. Vaccination might also prevent successive rounds of autoinnoculation and potentially decrease viral persistence and load, thus ultimately preventing cervical dysplasia.

Vaccine introduction into the developing world

It is clear that the use of injectable vaccines is going to be particularly difficult because of the cold chain. Current trials of aerosols and vectors such as Salmonella bacteria are promising. These would lead to lower production costs and make it easier and safer to administer vaccines. None the less, such trials will be expensive to undertake. There may be variability in response, particularly via the oral route, and the use of genetically modified organisms may be resisted by some groups in the community. Another approach has been the use of the L2 protein (capsid protein)

of the viral capsid which induces cross neutralizing antibodies across HPV 6, 16 and 18, although in smaller titres than other viral like particles (VLP).

Studies on current and safe proven vaccines repeatedly show that availability does not mean acceptance. For instance, only two-thirds of the elderly have flu injections, and only approximately one-third of eligible surgeons undertake to have Hep B vaccination. When one considers that HPV is a sexually transmitted disease, then the introduction of a vaccine for pre pubertal children remains quite controversial and there will undoubtedly be groups in the community who are quite uncomfortable with the concept. It is certainly clear that decisions about vaccination are strongly influenced by the family doctor, but it is not unrealistic to think that parents may worry that adolescent or pre pubescent child would interpret a parent's approval of a Sexually Transmitted Infection (STI) vaccine as condoning sexual behaviour. On the other hand there is encouraging study from Mexico where only 2% of the population studied knew of the link between HPV and cervix cancer, and following an education programme, 84% stated they would allow their doctors to vaccinate their children.

Summary

It is clear that the community's knowledge about HPV and its link to cervical cancer is woefully inadequate. The introduction of a vaccine against cervix cancer and/or genital warts requires a huge effort at both community and profession education. It is unclear as to whether Australia has the educational tools in place to set up such a programme, but it is also clear that such a programme is urgently needed.

Masculinity a health hazard

Carol Nader
Health Reporter

TRADITIONAL views about masculinity are damaging men's health and are partly to blame for men suffering significantly poorer health than women, according to Sex Discrimination Commissioner Pru Goward.

Ms Goward will tell a men's health conference in Melbourne today that the key to the "profound disparity" between men and women is *masculinity*.

"Masculinity, as it is commonly and traditionally defined, means an identity based on risk-taking," she said. "It means physically hard and onerous work under unacceptable health and safety standards, remembering that a lot of young male deaths occur as the result of taking risks at work."

Ms Goward will tell the conference that the life expectancy gap between men and women is seven years - in favour of women - and more than three times more men than women die before they are 35. Among 15 to 29-year-old males, the risk of accidental death is about four times higher than for women of the same age, suicide is six times higher and violence-related death is 1½ times higher.

Ms Goward's comments come as the co-director of the Men's Health Information and Resource Centre at the University of Western Sydney, Michael Woods, said there needed to be a national policy on men's health.

Ms Goward said society continued to reward men for courage and daring and achievements in invention, science and politics.

"But courage, daring and excessive self-belief in one's immortality also have an unnecessarily life-shortening downside for millions of men who do not discover the cure for cancer, become prime minister or get to run BHP," she said. "They live ordinary lives unnecessarily cut short by their efforts to live up to expectations that can have serious consequences for their health, their family relationships and their connections to community."

Ms Goward said if men spent more time with their children and did more housework, it would improve their physical and mental health, make them less likely to engage in risk-taking behaviour, and give them skills traditionally allocated to women.

"What we need to confront is the outdated belief that men are impregnable, that risking life and limb is OK, that medical checkups, diets and keep-fit regimes are to be avoided as unnecessary, that a man's job is never more than bringing home the bacon, and that their families do not need them as much as mothers," she said. "Instead, Men should be as sure as women that they must live, and live healthy lives, for all their sakes."

(The Age, Wednesday 12 October 2004, Page3)

Victorian Cytology Service - Service Profile

From humble beginnings VCS is now recognised as a leader in its field, highly respected both in Australia and internationally. Reporting almost 300,000 conventional Pap tests per annum (approximately half of Victoria's Pap tests) it is the single largest laboratory reporting Pap tests in Australasia. VCS is now the only public laboratory remaining in Australia that specialises in cervical screening.

VCS is a not-for-profit organisation and offer the following services:

| | |
|-----------------------------------|---|
| Conventional Pap Tests | Free service. No need to sign the Medicare Assignment. |
| HPV / Chlamydia by Hybrid Capture | May be Medicare funded in some circumstances. Please have the woman sign the Medicare Assignment where relevant |
| ThinPrep Pap Test | A charge of \$36.00 applies. We will send an account directly to the woman. |
| Histopathology | Medicare funded. Please have the woman sign the Medicare Assignment on the laboratory request form. |

Histopathology

- < VCS pathologists specialise in gynaecological cases and are experts in their field
- < VCS reports about half of Pap tests taken in Victoria so Pap tests taken prior to biopsy are often immediately available for review and correlation
- < Our quality assurance procedures correlate cervical cytology and histology results to ensure that each case receives the most comprehensive analysis
- < Histology results are available with 24/48 hours
- < VCS histology is bulk-billed (or billed at the Medicare rebate fee) so patients are not out-of-pocket.

Quality

- < VCS is accredited to AS ISO/IEC 17025:1999
- < The organisation is committed to meeting all relevant industry standards of NATA, NPAAC and RCPA
- < VCS participates in the Royal College of Pathologists Australia Quality Assurance Programs and the American Society for Clinical Pathology Accreditation programs
- < Performance standards of scientific and medical staff are monitored against industry and in-house performance measurements and managed through a Quality Committee.

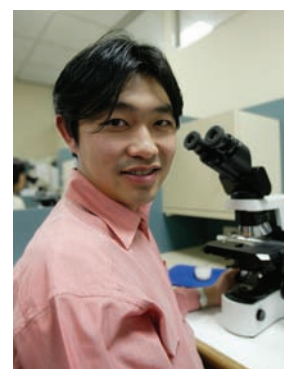
Support for Taking Smears and Result Management

- < Specialist advice
- < Free training on taking quality cervical tests
- < Cervical screening education program
- < Educational workshops and practice visits
- < Educational material
- < Courier Service

Contribution to Cervical Screening Programme

VCS as a public laboratory plays an integral role in the cervical screening programme: -

- < Teaching and training centre for Diagnostic Cytology, training Cytopathologists and Cytologists paid internships, students on placement, in-house education and formal training courses (university tertiary level).
- < Conducting / supporting scientific research for the prevention of cervical cancer, new technologies etc.
- < Assisting state and federal governments with policy formulation.
- < Providing educational sessions for medical practitioners and health professionals to assist them in refining their skills and improving the way Pap smears are performed.
- < Supporting Victorian Cervical Cytology Registry - the Registry is a confidential, computerized database of Victorian women's Pap test results. The main function of VCCR is to facilitate the regular participation of women in the National Cervical Screening Program by sending reminder letters around the time when their next Pap test is due, and to provide a safety net for the follow-up of women with abnormal Pap tests.



To discuss your gynaecological pathology service requirements, please telephone Lisa Garay, Customer Services Manager at VCS on 9250 0300 or email at lgaray@vcs.org.au.



Victorian Cytology Service

Victorian Cytology Service Pap smears are free

What Have We Gained?

At a gathering of retired doctors the talk soon turned to their days in practice ...

"In our day," recalled a physician "we were first and foremost consultants for patients in our hospitals. We were not into service management! That was left to our medical superintendent and his approachable staff. And our hospitals were ably ruled by their own boards, which had their fair share of doctors."

And someone said, "All this has gone."

A surgeon continued, "We had the respect of society and people called the hospital their own. We had doctors' car parks and dining rooms. We were valued as staff and we valued our hospital."

And someone said, "All this has gone."

A GP joined in: "Life was not easy. We had to dress up in those white uniforms, cover our patients 24 hours a day one day in three, and work more than 80 hours a week. But we were proud to serve and learn."

And again was heard, "All this has gone."

"What do we have now?" a radiologist asked. "Medical staff are marginalised and medical superintendents have been displaced by managers who slavishly comply with edicts from distant departments of health. Individual hospital boards have been swallowed by area health boards on which doctors cannot serve - conflict of interest, you know."

Continued the surgeon, "Doctors no longer identify with their hospitals and nor do local people. Who would blame them?! They have long and anxious waits in emergency departments or on waiting lists." And a pathologist added, "Junior doctors no longer live in and work in shifts. Worse still, doctors are now pawns in the bureaucrats' battles with the bottom line."

And came the remark, "What have we gained? ... "



Martin B Van Der Weyden
(MJA. Volume 183 Number 6.19 September 2005)

Advertising Antics

In Plato's Republic, two ancient Athenian philosophers, Socrates and Thrasymachus, probe the essence of medicine and healing:

Socrates: "Tell me: is a doctor in the precise sense ... a money-maker or someone who treats the sick? Tell me about the one who is really a doctor."

Thrasymachus: "He's the one who treats the sick."

It seems that even the ancients explored the intrinsic conflict between caring and commerce in medicine. Today, the relevance of this conflict has grown, as commercialism and its culture of creating wealth infiltrate health care.

Essential to this process is advertising.

Once, the medical profession regarded advertising with disdain. Professional reputations and expertise had always been spread by word of mouth. Alas, no more. Now the media proclaim the availability of "unrivalled" medical services. These newcomers are commercial concerns capitalising on medical technology.

Promotions lauding their services are delivered by celebrities, and Australians are urged to screen for potential "nasties" by having total body scans. This is despite the fact that health authorities are so concerned about total body scans that in 2004 they issued a public health alert: "Full body scans ... involve doses of radiation that health experts do not consider to be justifiable in terms of a health check".

But the promos push consumer rights: "You have the right to know ... what might be waiting to make you sick." And recently, there has been a disturbing twist in advertisements which seems to threaten the independence of medical practice: "Your doctor may advise you not to waste your time or money - but is he willing to take legal responsibility if he's wrong? Insist on a referral."

We hear a lot from our health ministers about transparency and ethical conduct for doctors. We may well ask whether the advertising antics of some health care businesses are also on their radar?



Martin B Van Der Weyden
(MJA. Volume 183 Number 3. 1 August 2005)

The Tree Of Hippocrates

Beside the drive leading to the United States National Library of Medicine (NLM) stands the Tree of Hippocrates. Given to the US by the people of the Greek island of Cos in the early 1960s, this tree was grown from a cutting from the very tree under which, as legend would have it, Hippocrates conducted his classes.

The library's links with medicine's history continue with its extraordinary collection of historical books. These include Vesalius' ground-breaking expose of human anatomy (1543), Ambroise Pares magnus opus on his surgical techniques and wisdom (1585), Harvey's revolutionary unravelling of the circulation (1628), Morgagni's clinico-pathological observations that launched modern pathology (1761), and Jenner's seminal treatise on smallpox (1798). There are also works by Galen, Paracelsus, Boerhaave and Osler, among others.

To see, touch and read these original tomes is to connect with the growth of medical science and practice through the ages, and to reflect on the endeavours of physicians as their questioning moved from, Who caused this illness? to, What is the illness, why does it occur and what can be done?

Modern medicine's overwhelming preoccupation with these questions is mirrored in the sheer enormity of the NLM's immediate neighbour, the National Institutes of Health (NIH). NIH's Bethesda campus is a scientific metropolis of 19 institutes and seven centres, in which almost 6000 scientists work, supported by about 10% of the annual NIH budget of US\$28 billion!

Early this year, when visiting the NLM and standing by the Tree of Hippocrates, I could not help thinking how little medical history is treasured and taught in our medical schools, and how today's reductionistic style of medicine has diminished the holistic approach taught so long ago under a tree on the island of Cos.



Martin B Van Der Weyden
(MJA. Volume 183 Number 5.5 September 2005)

Patients and Teaching and Training

Recently, the relative peace of a public hospital clinic was shattered by the loud protestations of a patient. On being approached by a registrar and a medical student, he dismissed both out of hand. He was not going to be seen by "junior doctors!" He wanted a "real doctor - the specialist!". Not surprisingly, this dismissal caused the registrar and student some distress.

Versions of this attitude are part and parcel of our teaching hospitals. Most medical students will remember instances of being dismissed by patients or sent away by guardians of the wards.

And with the ascendancy of consumerism and individual autonomy, patients choosing to not be part of clinical teaching or training may well become more common. This scenario is even more likely in light of increasing student numbers in a setting in which teaching resources are already stretched.

Should society expect its citizens to be involved in the teaching and training of future doctors? Some people argue that there is a moral obligation to participate in these activities. After all, society expects doctors to be competent and capable, and these attributes do not simply materialise.

Just as today's patients reap the benefits of yesterday's patients' participation in clinical education, is it not reasonable that today's patients reciprocate for the benefit of tomorrow's patients? Unfortunately, the prevailing cult of the individual, which values "my choice" and "my rights", places a correspondingly low value on the needs of the community.

Increasingly, medical schools are adding another leg to the three-legged stool they talk about - to teaching, research and patient care is added social accountability.

But social accountability is a two-way street - particularly so in clinical teaching and training.



Martin B Van Der Weyden
(MJA. Volume 183 Number 4.15 August 2005)

Health And Happiness

Longevity has our society in its thrall. In a community riddled with dissent and focused remorselessly on the individual, the one thing guaranteed to galvanise agreement is the notion that to live longer and longer is a good thing.

Daily, we are bombarded with research outcomes that promise health and happiness, and add to the medicalisation of our lives. We are advised on what to eat, how to exercise, and the optimal amounts of sleep, sex and alcohol we can enjoy with relative impunity. Comply, and a long and healthy life is ours - but in the process, do we lose our joie de vivre?

Japan, the world's leader in longevity, now exhorts its citizens to defend their status by abandoning Western lifestyles and returning to the tried and tested traditional regimen of fish, rice and miso and consuming less meat, bread, pasta and coffee. Reducing stress-filled, sedentary lives has become a national goal.

At home, we are more relaxed about these matters. The blueprint of the national goal Promoting and maintaining good health, announced in 2003, has yet to see the light

of day. Not to worry; we can always consult the deluge of media advice on achieving health and happiness.

Modernity's aggressive medicalisation of our lives is captured in a caricature written almost 30 years ago: "... [a man] lacking in physical or mental alertness and without drive, ambition, or competitive spirit ... subsisting on fruits and vegetables laced with corn and whale oil, detesting tobacco ... [and] constantly straining his puny muscles by exercise. Low in ... blood pressure, blood sugar, uric acid and cholesterol, he has been taking nicotinic acid, pyridoxine and long term anti-coagulant therapy ever since his prophylactic castration."

And all for a long life!

Health in pursuit of a long life is a modern religion. But are we happy?



Martin B Van Der Weyden

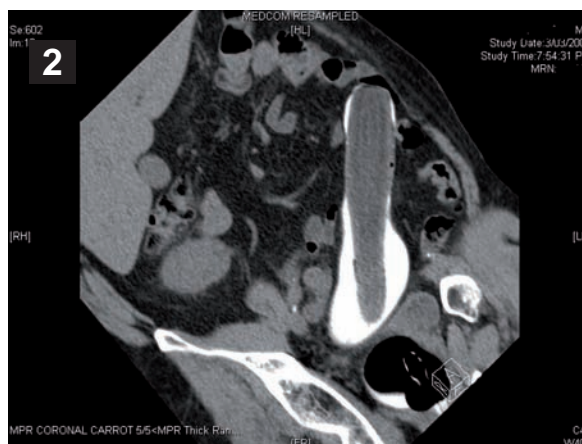
(MJA. Volume 183 Number 10.21 November 2005)

Interesting Cases from Dr Lean-Peng CHEAH

1. Married to his job: A mechanic while fitting a car wheel, called in the fire-brigade to remove a metal nut from his ring finger. He refused amputation!



2. At your Cervix, madam: A wellknown gentleman was too forward at foreplay; he lost a carrot.



3a & 3b. Catastrophy: A 60 years old man had an unsuccessful ventral hernia repair following cardiac arrest and retroperitoneal haematoma syndrome.



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The Wooden Bowl

A frail old man went to live with his son, daughter-in-law, and four-year old grandson. The old man's hands trembled, his eyesight was blurred, and his step faltered. The family ate together at the table.

But the elderly grandfather's shaky hands and failing sight made eating difficult. Peas rolled off his spoon onto the floor. When he grasped the glass, milk spilled on the tablecloth.

The son and daughter-in-law became irritated with the mess. "We must do something about father," said the son. "I've had enough of his spilled milk, noisy eating, and food on the floor."

So the husband and wife set a small table in the corner. There, Grandfather ate alone while the rest of the family enjoyed dinner. Since Grandfather had broken a dish or two, his food was served in a wooden bowl!

When the family glanced in Grandfather's direction, sometime he had a tear in his eye as he sat alone. Still, the only words the couple had for him were sharp admonitions when he dropped a fork or spilled food.

The four-year-old watched it all in silence.

One evening before supper, the father noticed his son playing with wood scraps on the floor. He asked the child sweetly, "What are you making?" Just as sweetly, the boy responded, "Oh, I am making a little bowl for you and Mama to eat your food in when I grow up." The four-year-old smiled and went back to work.

The words so struck the parents so that they were speechless. Then tears started to stream down their cheeks. Though no word was spoken, both knew what must be done.

That evening the husband took Grandfather's hand and gently led him back to the family table. For the remainder of his days he ate every meal with the family. And for some reason, neither husband nor wife seemed to care any longer when a fork was dropped, milk spilled, or the tablecloth soiled.

(sent in by a reader of Qi Magazine and friend of ACMAV colleague)

Editor's comments: Let not the young abandon the old, nor the old forget to teach the young.

I've Learned

On a positive note, I've learned that, no matter what happens, how bad it seems today, life does go on, and it will be better tomorrow.

I've learned that you can tell a lot about a person by the way he/she handles three things: a rainy day, lost luggage, and tangled Christmas tree lights.

I've learned that, regardless of your relationship with your parents, you'll miss them when they're gone from your life.

I've learned that making a "living" is not the same thing as making a "life."

I've learned that life sometimes gives you a second chance.

I've learned that you shouldn't go through life with a catcher's mitt on both hands. You need to be able to throw something back.

I've learned that if you pursue happiness, it will elude you. But, if you focus on your family, your friends, the needs of others, your work and doing the very best you can, happiness will find you.

I've learned that whenever I decide something with an open heart, I usually make the right decision.

I've learned that even when I have pains, I don't have to be one.

I've learned that every day, you should reach out and touch someone.

People love that human touch -- holding hands, a warm hug, or just a friendly pat on the back.

(Anonymous)



Kaleidoscope

Overseas Aid

Travelogue

and

Culinary Report

The Old Boy

Frank Thien and Siew-Khin Tang

Dr Choong Khean Foo, whom we all know as Benny, has been an endearing as well as enduring personality in the ACMAV. He was one of our founding Committee Members in 1985 and had been a strong supporter through its early formative years, before taking the helm as President in 2002-3. Through his Presidency, he has skilfully guided the ACMAV with wisdom and experience, as well as showing courage and initiative to take the Association in new directions with humanitarian aid projects such as Project Africa, Project Mongolia and Project Compassion.

Born in Ipoh, West Malaysia, Benny came to Melbourne for his schooling and on matriculation was accepted into University of Melbourne medical school. After graduating in 1960 he worked as a resident in St Vincent's Hospital, and then as Medical Officer in Singapore General Hospital. His employment at the Emergency and Outpatient department in Singapore would have been an eye-opener for him, as the population of nearly 3 million inhabitants had only 8 medical officers stationed at any one time attending to the sick at the outpatient clinics. The pressure of work did not faz Benny as he had other interest. He was the envy of his more sedate colleagues, as it meant favourable posting for a "new-comer" who was no threat to the boss!

He then joined a group General Practice in Singapore, practicing Family Medicine, Aviation and Industrial Medicine between 1962 and 1977. In 1977, he returned to Melbourne with his wife, Pauline, and 5 children and set up General Practice with a focus on Holistic Medicine, in Hawthorn which has been his 'home base' until 2000. He

joined the Australian Medical Acupuncture Society in 1977 and was granted a Fellowship in 1978. He rose through the ranks of the Society taking on the roles of Secretary and President of the Victorian branch between 1981 and 1985, and was elected to the Federal body being Secretary from 1986–1988 and subsequently President between 1988 and 1989. Benny has maintained a keen interest in professional education, lecturing in acupuncture courses for the RACGP, as well as directing and coordinating courses for the Australian Acupuncture Foundation, Australian Academy of Holistic Medicine, and RMIT University. His commitment to continuing education also led to completing a Postgraduate Diploma in Orthomolecular Nutrition (International Academy of Nutrition) in 1982 and a Masters of Applied Science (Medical Acupuncture) at RMIT University in 1997. His expertise has also been sought to advise to RMIT University on the Chinese Medicine course and on Integrative Medicine to Swinburne University of Technology. Outside of medicine, Benny's interests include photography, travel, classical music, reading, writing, cooking and meditation. If one is on Benny's email list, one will always be entertained by poems and wise messages.

Through his leadership, he has given the ACMAV an enduring legacy of orientation towards compassionate aid work. In his own words, Benny's philosophy of life is:

"In order to achieve optimal health we must live in harmony with Mother Nature. We are not only what we eat but also what we think, what we see, what we hear and what we feel and touch. Share the knowledge of proper diet and nutrition for disease prevention and health promotion. Help those who are in need. Give generously."

PROJECT VIETNAM

Theong Low

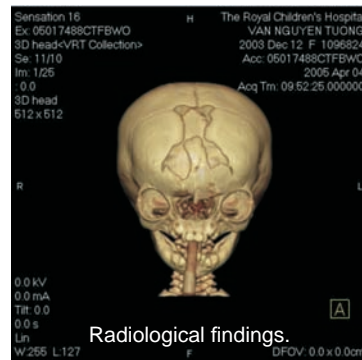
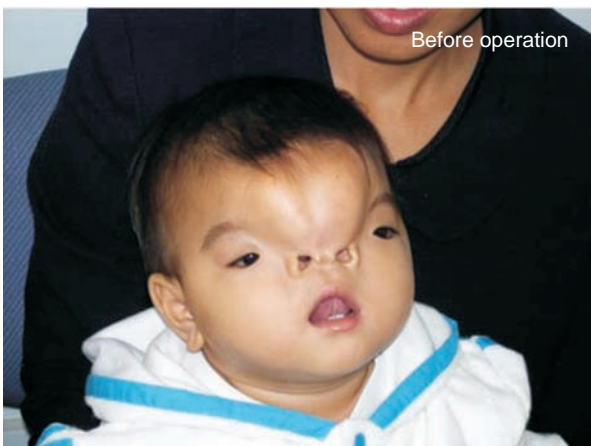
18 month old Miss Tuong Van Nguyen, from the coastal fishing village of Chi Cong in South Vietnam arrived in Melbourne on the 19th March 2005 for life transforming surgery. She is the only daughter of Mr. Binh Nguyen and Ms. Thi Be Ho. Her identical twin died 4 days after birth. She was sponsored by ACMAV as part of our Community Service Project.

It was the hard work and expert networking between our ACMAV member and surgeons of the Royal Children's Hospital (RCH) that this project came to a successful outcome for the infant.

She was born with Bilateral Tessier 1 clefts, Syncipital Encephalocoele, and Hypertelorism. There is no surgical expertise in Vietnam to treat such deformities and often these kids are left in orphanages to be looked after by care-givers. Superstition considered it punishment for their parents' past wrong-doings and they are often rejected by family members. Tuong Van however is one of the lucky infants who remained with her family.

On arrival in Melbourne she had pre-operative assessment including CT scans, 3D cranial volume analysis at the RCH.

Tuong Van had major craniofacial reconstructive surgical procedure performed at the RCH under the care of Mr Anthony Holmes and Mr. Patrick Lo on the 19th April 2005. The procedure was eventful and prolonged (~13

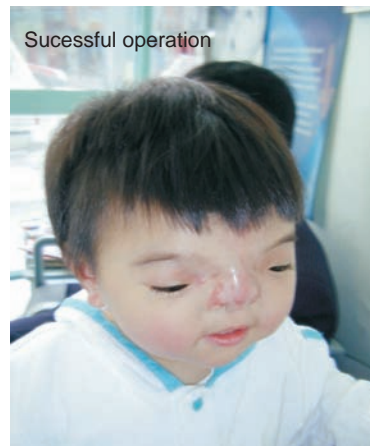


hours). Complications including desaturation/cardiovascular instability and difficult ventilation/raised pulmonary vascular pressures culminating in intraoperative cardiac arrest which required resuscitation.

The expert care and dedication of the medical team at RCH resulted in recovery from these life threatening episodes.

Post-operatively, she was admitted to ICU due to failed extubation. She remained intubated until day 4 and CVC tube was removed on day 9. Subsequent complications included alar flap necrosis and wound infection. In spite of these tremendous hurdles and mishaps, she recovered and was subsequently discharged on the 23rd May 2005, five weeks after her operation.

She was readmitted on the 8th August 2005 for secondary bone graft and nasal reconstruction. The result of the arduous task can only be appreciated by the expression on the faces of all who cared for her, when she was farewelled for her return to Vietnam on 17th September.



Tuong Van now lives happily with her family on her return to her village. She is a very lively little girl and should be able to live a normal life, which would have been difficult given the extreme facial and cephalic abnormalities she was born with.

Liberia Female Tract Fistulas In The Developing Country 2005

Judith Goh

Prolonged obstructed and neglected labour is the most common cause of genitor-urinary fistula worldwide. On average the women who develop genital tract fistulas labour for long periods, fever lasting over 4 days and over 90% deliver a stillborn baby. The fistula is due to pressure necrosis from the baby's presenting part (usually head) being in the vagina for prolonged periods of time. This results in loss of tissue between the vagina and the urethra/bladder together with necrosis in tissues between the vagina and rectum/anus. Thus, the fistula or abnormal communication between the lower urinary tract (and/or rectum) and vagina with absolute loss of control of urine and/or feces (in those with rectovaginal fistulas), the incontinence resulting in accumulation of waste products in the vagina.

The women who develop fistulas often become outcasts as are an embarrassment to their friends and families. They are abandoned by their husbands and family. It is estimated that worldwide, over 100,000 women develop fistulas annually and at the present time there are at least 3 million women with fistulas.

Successful anatomical closure of fistulas may be achieved in up to 90% of women in specialized fistula units. Post-fistula complications, such as pelvic organ dysfunction,

reproductive and sexual dysfunction and health issues do occur following fistula repair.

Liberia

This year, during mid-April to early May, I spent time on the ship called the Anastasis, part of the Mercy Ship fleet I went on board as the fistula surgeon. This year, the Anastasis was docked in Monrovia, Liberia. The docking site for 2006 will also be at this post.

Liberia is a West African country, with a population of about 3.4 million. Liberia has been through a civil war, and today, about 15000 UN troops are in the country. Election are expected to be held in October 2005.

War has caused significant problems such as the lack of electricity and running water, even in the capital city of Monrovia. As with many developing countries, health is a major issue. The estimated there are 2 doctors per 100 000 people. Most of the people live in poverty.

As a visitor to Liberia, I found it not too different to other East and West African countries I had previously visited. The people are poor, there is little infrastructure. There is



Fig. 1: Transporting water



Fig. 2: From Left to right: myself, Frances (in her new dress) and a member of the nursing staff on the ward.

no organized waste disposal and hence it is common to find rubbish on the streets and waterways. Water is a precious commodity, and some make a living by transporting water in plastic containers into town (see Figure 1)

A common feature in Liberia is the presence of UN troops. There are many check points with razor wires, armed guards and war tanks at most check points. It is uncommon to find a convoy of tanks rumbling through town.

It is generally safe to travel in a group during the day, and even at night as long as one is aware of the local situation. The UN was supportive of the work of the Mercy Ships and kept the captain informed of possible local unrest should this occur. There was one weekend when all crew shore leave cancelled by the captain because of potential unrest at the port due to UN activity.

Mercy Ships

Last year, I spent time on the Anastasis. She was docked in Freetown, Sierra Leone next year. I will be returning to the Anastasis and back to Liberia, in January 2006.

The Mercy Ship is a charitable Christian organization (www.mercyships.org). The Anastasis has about 350 crew members. It is a hospital ship, with 3 operating theatres and a 40 bed ward. The crew live on board. All crew are volunteers who pay for their travel to the ship and for food and accommodation on board. The cabins hold 3 or 6 bunks and there are a small number of family cabins for permanent crew member with families.

Volunteers may spend a couple of weeks to a few months on board. Apart from medical and nursing volunteers, the crew also provide dental care and off shore services such as community health training, HIV/AIDS awareness education and training programs for local health care with the emphasis on skill-transfer to the local healthcare workers. They also conduct literacy classes, assist in rebuilding of schools, orphanages and skill-transfer to the locals. Many of the crew also keep the ship running by doing engineering, maintenance work, and cooking and administrative duties. The ship employs local translators.

The Anastasis has 3 operating theatres with one of the theatres devoted fistula surgery. Another is for ophthalmic surgery (mainly cataracts) and the remaining theatre for facio-maxillary surgeon, catering to many people with huge tumours of the face, head and neck. The surgeons will operate if the tumour is benign. The facio-maxillary surgeon also perform many reconstructions from faces destroyed by trauma (war injuries, disfigurement cause by infection) or congenital abnormalities (such as cleft palate/lip).

I operate on an older woman called Frances in Liberia. Frances was angry with the world, with God and with life. She cannot remember how old she is but looks about 50. She told me she has the fistula for over 30 year and has been abandoned by everyone. Frances is a small slim woman. I made a spot diagnosis of urinary fistula once she walked into the consulting room as she smelt of urine. On examination, Frances had a 2 cm fistula between the vagina and bladder. The vagina was not very scarred. Two weeks following surgery, Frances left, and extremely happy lady free from the stench of urine. We could all see the change in her during her stay on the ship in the post-operative period. Initially, she was quiet and withdrawn but after a week, she started smiling as she is no longer wet with urine even though the urinary catheter was still in situ. After 10 days, she would call me over to tell me she was dry. A couple of days later, I could not get past her bed during ward rounds as she wanted to tell me everything - her whole life story. When the catheter came out after 2 weeks and she remained dry, we could not shut her up! We sent Frances off with a new dress, as a symbol of a new start. The farewell ceremony involved dancing and singing with music African style. Frances danced and sang, thanked everyone, including God. It was a privilege to participate in her care.

I would encourage people to go overseas, in particular, to developing country to work. There are many opportunities, not only on Mercy Ships, Personally, it helped me to appreciate what I have here in Australia and not to complain so much. It helped give my life a bigger frame - a bigger picture.

Aida at the Arena de Verona

Khai Yuen Tang



Fig 1: Santa Margherita Ligure

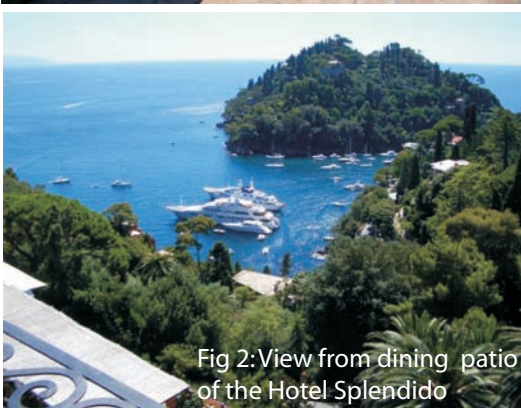


Fig 2: View from dining patio of the Hotel Splendido



Fig 3: Portofino harbour



Fig 5: St Marks Square with puddles



Fig 7: Entrance of Arena de Verona

I had the opportunity to visit Nice and the French part of the Riviera in 2004 when my wife and I attended a conference on “HPV and Cervical cancer” in Nice.

The Riviera is a region in southern Europe, consisting of a narrow coastal strip that extends along the Mediterranean Sea from Hyères, France in the west, to La Spezia, Italy at the eastern end of the strip. The area is a world famous holiday resort. Towns on the French Riviera, also popularly called the Côte d’Azur (Azure Coast), include Saint-Tropez, Antibes, Cannes, Nice, Menton, and Monte Carlo (in the principality of Monaco).

The Italian Riviera is divided into the Riviera di Ponente (Coast of the Setting Sun), extending west from Genoa, and the Riviera di Levante (Coast of the Rising Sun), east of Genoa. Other noted towns on the Italian Riviera are San Remo, Portofino, Santa Margherita Ligure, and Rapallo. The Riviera has a mild climate, resulting in delicious fruits such as pomegranates, figs, oranges, lemons, and persimmons.

We toured the region rather extensively at that time using a rented car from Hertz and stopping in a few of the interesting towns along the coast, as well as further inland e.g. Provence, but we did not go across the French/Italian border on the eastern end of the

coastal strip because of insurance problems with the rented car, as the car was only insured for use in France and not Italy.

In June 2005, a friend from Singapore and I made a trip to Verona to see a performance of Aida at the annual Verona Opera Festival held in the Arena de Verona, a venue made more famous by the three tenors. We also visited Portofino in the Italian Riviera, so that I will have visited the whole of the Riviera following my trip in the previous year!

A booking for seats to “Aida” was made on the internet directly with the company in Verona for the best reserved seats for Sunday August 21. I travelled by Singapore Airlines with a stop-over in Singapore where I spent a couple of days and together with my friend from Singapore we flew to Rome. After a two-hour stop we proceeded to Genoa. We were fetched at the airport by a limousine provided by the Hotel Splendido, Portofino, where we stayed. We drove into Portofino going through Rapallo and Santa Margherita Ligure. Both these seaside resorts have beauti-



Fig 6: Restaurant in Venice

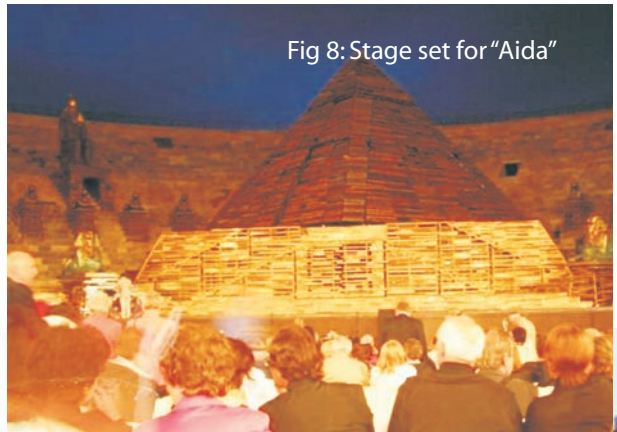


Fig 8: Stage set for “Aida”

Fig 4: Camogli



ful beaches and the surrounding sea is really blue. In fact I was so captured by the splendour of Santa Margherita that on the following day we took a boat ride to visit the town and study it in more detail (Photo 1 – Santa Margherita Ligure) as it is just about 45 minutes by boat from Portofino, a seaside resort about one hour's drive by car to the south east of Genoa. The Splendido is a fabulous hotel perched on the side of a hill almost near the top. It offers a tremendous view of the nearby Mediterranean Sea and the vista from the dining room and patio is a picture perfect scene (Photo 2 – view from dining patio of the Hotel Splendido).

The port of Portofino is very picturesque and has a central harbour where ships and yachts of all varieties and nationalities can be seen; they are all magnificent (Photo 3 - Portofino harbour). Surrounding this harbour are the usual cafes, restaurants, gift shops, a pharmacy and a couple of banks.

We spent 4 days and 3 nights here. On the last day the hotel supplied us with a boat and a pilot. The pilot took us to some of the neighbouring towns, one of which, Fruituoso, was only accessible by sea and was not approachable by roads. Hoping to see more of the area in that one afternoon, we by-passed this town and instead visited another town further away from Portofino. This town, Camogli, was not much different from all the other towns along the Riviera, with brilliant views, fabulous white beaches and the usual restaurants and shops. (Photo 4 – Camogli)

The following morning we departed for Verona via Venice, where we stayed in the Bologna Hotel just to the back of the famous St Marks Square, which unfortunately is reported to be “sinking” into the Mediterranean (Photo 5 – sinking St Marks Square). One can see water from the sea seeping into St Marks square and at high tide the puddles of water can be quite large – about 20 feet in diameter. We visited the Duke's palace briefly and had quite a memorable dinner of lobster with a bottle of excellent Italian wine while being looked after by an extremely friendly and helpful waiter from Croatia. Needless to say he was given a handsome tip for all his efforts. (Photo 6 – restaurant).

Then towards evening it was time to depart for the highlight of the trip – to Verona and the performance of Aida at the Arena. We opted to travel to Verona by train. In retrospect, this was a bad decision. Italian trains are not noted for their punctuality and the layout of the platforms leaves much to be desired. The platforms from which particular trains depart are left un-posted until about 5 minutes prior to departure and the rush of people to the correct platform (me with my luggage trailing behind) was just too much for me; I promised myself that I will never travel by train in Italy again if I can help it. It would have been far better to have taken a taxi or even hired a one way rental car from Venice to Verona.

Our hotel in Verona was very small and the rooms were tiny but had ensuite bathrooms and clean, so I really did not fuss too much. Moreover it was very conveniently situated right opposite the Arena. In fact from the dining hall one could get a very good view of the main entrance to the Arena. (Photo 7. Entrance of Arena from dining Hall). The performance which was scheduled for Sunday kept us all excited and we had an early dinner that evening. Some gypsies had gathered by the open-air dining hall and provided us with appropriate music. After dinner we went early to the Arena and settled in, hoping to be entertained to an almost perfect performance of Aida. However this was spoilt by the odd drizzle that one had to contend with as the venue is an open-air theatre. All too soon the performance was over and we had spent our last night in Verona. (Photo 8 – Set of Aida). The following morning we flew from Verona to Rome where we spent one night at the Hotel Majestic and then it was home to Melbourne.

There is a lesson to be learnt from this experience. It is best to opt for indoor performances where the elements do not interfere with one's enjoyment of a performance. I well remember the time when Aida was performed in Melbourne at Princes Park. It was some years ago now, but on the night of the performance, there was a strong wind blowing and the animals which participated in the triumphal scene just would not settle down, causing much distraction to the enjoyment of the performance. It looks as though the next overseas opera trip that I plan for will have to be one performed indoors - at La Scala perhaps!

Out of Africa

Ming Li Chong

“Karibu”- Welcome. We were greeted by Father Fidelis and Father Mrosso, from the Saint Camellius Mission in Yombo at the airport. We have finally arrived in Dar es Salaam, Tanzania. Tanzania is East Africa’s largest country, almost four times the size of UK. It has a population of 35 million with Dar es Salaam comprising 3.5 million. Tanzania’s highest mountain is Mt Kilimanjaro. There are the many national parks in Tanzania especially the northern safari circuit around Arusha and the Serengeti plains, and the Zanzibar Archipelago. In history, Zanzibar was an important trading post for spices and slaves, comprising of many tribal groups of Asians, Arabs, and Europeans with vast majority being of Bantu origin and other minority groups including the Masai and the Iraqw. Along with English, Swahili is the other official language which derived from African, Arabian, Indian, Asian and the European (the Portuguese, Germans and British) influences.

From the airport, all thirteen of us were “ingeniously” transported to the Saint Camellius Mission in a truck that only seats five people. We were welcomed by Father Louie, and accompanied by Father Safari, were given a tour of the mission. The mission is located in Yombo, a low socio-economic area, near the airport. The parish has a small attached hospital. The hospital employs a trained clinical assistant, and treats about 150 people per day. It is too expensive for the parish to employ a fully trained doctor which will cost about US \$200 per month. The clinical assistant is paid US \$100 per month whereas other staff members are paid US \$25 per month. The doctor: population ratio is 1: 200,000. The hospital has a small pharmacy and a basic laboratory which has a centrifuge machine and a microscope for examining blood films in malaria cases. It has one delivery room and eight post natal beds and boasts of fifty uncomplicated deliveries per month. Common diseases treated are malaria (comprises of 50% of the cases), gastroenteritis, HIV and other infectious diseases. Medical consultation and medications are subsidized at the parish hospital. HIV counseling services are also provided. The cost

of running the medical facility is US \$3,000 per month. On behalf of ACMAV, we donated some drugs (Amoxicillin, Paracetamol) and other small gifts to the mission.

Arusha

From Dar es Salaam, we flew to the Kilimanjaro International Airport and then drove another 45 minutes to Arusha. Arusha is the gateway to Serengeti and other parks in the north. It is the main centre for organizing safari and trekking to the national parks, Mount Kilimanjaro and Mount Meru. Arusha lies near the foot of Mount Meru. In the centre of the town is the clock tower roundabout which marks the halfway point between the Cape of Good Hope and Cairo. Arusha was where the United Nations Tribunal sat for the conference discussing Rwanda genocide. We spent the night at Arusha. Our hotel porter works hard for his dollar. He only earns about US \$46 per month what the cost of basic needs for his family will cost US \$2 per day.

From Arusha, we travel west to Lake Manyara, passing coffee plantations and a number of churches of different denominations. On the way, we passed by Mto Wa Mbo (Swahili for Mosquito Creek), known for its lively market and sale of produce.

The Great Rift Valley

The Great Rift Valley is part of the East African rift system, a massive geophysical fault stretching across the African continent from the Dead Sea in the north to Beira, Mozambique in the south. The rift system was formed more than thirty million years ago when the tectonic plates that comprise the African and Eurasian land masses collided and then diverged. As the plates moved apart, large chunks of the earth crust dropped down between them. Over the millennia, these movements resulted in the escarpment, ravines, flatlands and lakes that characterize East Africa’s topography. The escarpments in Tanzania’s portions of the

Rift Valley are most impressive in the north, in and around the Ngorongoro Conservation Area and the Lake Manyara National Park.

Lake Manyara National Park

This park is about 1700 metres above sea level and lies at the foot of the western wall of the Rift Valley escarpment. Lake Manyara was made a national park in 1960 and covers an area of 330 square kilometers. About two thirds of the park is covered by Lake Manyara, which is a soda lake. Despite this, the park has a variety of habitats which is able to support a large variety of animal and bird species. The park is famous for its elephants and tree climbing lions. There were numerous elephants, baboons, blue monkeys, vervet monkeys, giraffes, wildebeests, zebras, marabout stocks, Egyptian geese, and guinea fowls.

Olduvai Gorge

Olduvai Gorge is a fifty kilometer ravine of an important archaeological site. The gorge is located at the border of the Ngorongoro Conservation Area and the Serengeti National Park. Olduvai is a mispronunciation of Oldupai, a Masai word for a type of wild sisal found around the gorge. The geological strata exposed in the gorge reveals a record of animal and human evolution from about two million until fifteen thousand years ago. The range of stone tools, animal fossils, and fossil bones of hominids (pre Homo sapiens) and early Homo sapiens are in among the significant finds from the Olduvai. The hominid fossils show the evolution of humankind over a two-million year period and makes our emergence in the world as modern humans seem so recent. In the gorge at nearby Laetoli, a path of

3.75 million year old fossilized footprints was found by Dr Mary Leakey in 1975. It showed that three hominids (probably two adults and one child) had walked upright across the terrain ...

Serengeti National Park

Serengeti National Park lies in Northern Tanzania, it is renowned for great wildlife viewing of huge herds of wildebeest and zebra that migrate across the Masai Mara, in search of new grass. It has been a subject of many documentaries. The word Serengeti comes from the Masai language that means “endless plains” The park is well known for the unique wildlife lodges and beautiful rock outcrops or “kopjes” which rises out the plains. The park lies on the high plateau between the Ngorongoro Highlands to the east and Lake Victoria to the west. To the north are Kenya and the Masai Mara Game Reserve which forms the northern part of the Serengeti ecosystem. The park can be divided into four regions – hilly and wooded in the north,



short and long grass plains in the southeast, woodlands and black clay plains in the west and acacia woodlands and savannah in the centre. Each area of unique vegetation attracts different types of animals. Commonly found in the park apart from the wildebeest and zebras, are the various types of antelopes, Grants and Thomson gazelles, cape buffaloes, topi, giraffes, warthogs, hippos, jackals and hyenas. We saw three cheetahs early one morning we were amazed at their prowess in stalking a herd of Thomson gazelles. We also spotted a number of lions and leopards asleep and lounging on a branch of an acacia tree.

Seronera Wildlife Lodge which is ideally located in the middle of the national park was where we spent the night. Electricity and water are only available during limited periods. Water to the lodge is pumped from three boreholes located 15 kilometres away. The name Seronera is derived from the Masai word "Seroinet" named after a Masai boy who was killed by lion. The lodge is located at the edge of a transition zone where open grasslands meet the woodlands. Many of the flat topped acacia trees around the lodge are known as umbrella tree *Acacia tortilla* and are over 100 years old. Within the lodge grounds, easily seen, are hyraxes (a close relation to the elephants), vervet monkeys, mongooses, baboons and Agama lizards. The Agama lizards are flamboyantly brightly coloured, in an attempt to attract females and intimidate other males from invading their territory.

Ngorongoro Crater

It is the largest unbroken caldera in the world. It covers an area of 260 square kilometers with walls of over 600 metres high. The Ngorongoro volcano was formed by a geological fault in the eastern arm of the Great Rift Valley two to three million years ago. The crater was formed when the molten lava beneath the volcano rapidly withdrew causing the centre to collapse. The crater is home to a large variety of birds and animals. In the centre is Lake Magadi, a soda lake often visited by flocks of flamingoes. We managed to see four types of the important five animals in Africa, namely elephants, lions, leopard and buffalo. Unfortunately the rhinoceros was more elusive.

The Masai are allowed to bring their animals to graze in the crater but have to leave before dusk each day.

Masai

The Masai are striking figures in the landscape with their

red garments and long stick. They are typically dressed in red togas and sandals, the warrior's helmet-shaped hair style and short stabbing swords all bear similarities to those in the ancient Romans that once occupied North Africa. The origin of the Masai are thought to have been in North Africa and migrated along the River Nile into East Africa at about the 15th century, first settling in Kenya in the Lake Turkana area. They then moved onto the Serengeti and Ngorongoro in the 17th century. The Masai are thought to be a hybrid of the Nilotes (from the River Nile regions) and Hamites (originating from North Africa).

The Masais speak the Maa language. There are about 300,000 – 400,000 Masais in northern Tanzania and southern Kenya, with about 4000 Masai in the Ngorongoro area. They are pastoral nomads, their life centres around the cattle, it provides them with milk, blood and meat, with leather and skins for clothing. Cattle represent wealth and status, used for trading and as dowry for brides. Cattle are rarely killed except during special occasions such as birth, illness, retreats and ceremonies. For the Masai, their domestic livestock are special. The livestock are kept in a fenced ring in the centre of the village. The Masai live in the mud huts located on the outer perimeter of the fenced ring. (Grass is important, the domestic stock are dependent on the rain and the fresh grass it generates.) The environment and season determines the Masai's way of life and their movement. In recent years, the Masai are starting to earn their income through tourism; some groups charge a large fee from the tourists who wish to take photos and to visit their village.

Polygamy is common and marriages are arranged by elders. A man can have as many wives as he chooses as long as he can support them. We stopped to view a village with fifty huts – one for each wife of a man with fifty wives, 150 children and 30,000 cattle!

Victoria Falls, Zimbabwe

It is a must to visit to Victoria Falls on a visit to Africa. Victoria Falls is a town built as a result of tourism to Zimbabwe. 700 kilometres away from Harare, it is sheltered to some extent from the political turmoil. We spent an evening watching African traditional dances showcasing Makishi stilt and pole dances, Shangaan (a branch of the Zulu) and Nyau ritual dances. A boma dinner followed the dance, it is an African meal with choices of buffalo meat, warthog and ostrich kebabs.

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STAY YOUR OWN WAYSM

Destination *Dubai*

Ch'ng-Tan K Siew

Dubai, situated at the NE tip of the Arab Peninsula is the capital of the United Arab Emirates(UAE) which is made up of 7 sheikdoms. It offers wonderful hotels magnificent sporting facilities, great duty free shopping in the giant malls, unique sight seeing with pleasant climate during Oct to May. We were there in late May and was approximately 40+C with high humidity.

Sight seeing trips offered are the Jumeirah Mosque, wind-tower houses of Bastakia, Al Fahidi Fort, Dubai Museum, gold and spice souks, 4WP dune safari, dinner at a traditional Bedouin camp, camel riding, excursion to Fujairah via the Hajar Mountains etc. I enjoyed all these very much except the humidity caused one to be drenched with perspiration.

Burj Al Arab Hotel

We were curious to experience the only '7 star' hotel in the world, completed in 1999. I have read and heard about its beauty but I was so surprised when I was taken around after checking in.

It is a world landmark, as this hotel has put Dubai on the map. My 4 year old grandson exclaimed 'Pisa' when we showed him the pictures; it seems to lean to one side. It sits in the sea and you can only enter via a high security causeway with only residents' guests permitted to visit. Tiger Wood hit golf balls and Andra Agassi tennis balls from the helipad. I went with the intention of hitting a golf ball too. But I was told I had to pay about AUD 18000 to land with a helicopter.



Burj Al Arab Hotel, Dubai

The hotel consists of 202 double storey suites. They vary from 170 to 780 sqm. We were lucky to be upgraded to a two bedroom suite. The architecture, engineering and interior design belong to a world beyond my imagination. Every colour and shape are displayed, and some items are plated with 22k gold (I rubbed very hard but no gold came off!). This sounds ostentatious and vulgar but it is very elegant and chic. All the carpets are coordinated with furniture and decor.

There are many elegant stores in this magnificent hotel, one displaying a US\$575,000 gentleman's gold vest.

The foyer has many levels of water cascades with giant-size aquaria full of sea creatures. At the entrance, there is a very tall fountain that displays fire and water works nightly. A floor manager and his assistant took us to the 27th floor (54th) roof top restaurant to view *The Palm* and *The World*. These are man made land masses in the middle of the



Burj Al Arab Hotel, Dubai



Main Entrance of Burj Al Arab Hotel, Dubai

ocean. *The Palm* will be completed in 2006 and will have 40 hotels with many shops and dwellings/residences. From 2005, foreigners are allowed to own properties. (This is a great opportunity for all the doctors in ACMA to invest in property!). *The World* will be completed in 5 years.

When we entered our suite, an office with a computer is next to one of the many bars stocked with complimentary red wines and German water. There is a guest powder room facing the impressive semi-spiral staircase (20+ft high) with a huge chandelier from the ceiling. There are two enormous sitting rooms with gold plated walls, plasma TVS, fabulous furniture, lots of chic floral arrangements and fruit-bowls of tropical fruits. There is a dining room next to a full size kitchen.

Upstairs, two sitting rooms with two enormous palatial bedrooms, are equipped with TVs, many telephones, and a huge mirror above the bed. Each room has a dressing/luggage re room and two giant bathrooms. There were chocolates, figs, cookies etc on all the coffee tables. Each bathroom has a double jacuzzi with a curved tile painting on the ceiling. The shower has multiple jets from many

angles. The toiletries were all Hermes in regular size, with soaps, jells and creams. One wonders how these items would make one more presentable. The Egyptian cotton lines and dozens of pillows available are what I miss now. Windows are full length glass with remote control screens. In fact, everything is electronically controlled. The view is simply breathtaking.

Frois gra and Iranian caviar for breakfast is available. The big treat was when the submarine took us to the underwater restaurant where walls were glass-lined with fish swimming around while we dined. The 18th floor has male, female or mixed spas with full sized pools. The outdoor pool area is on the 1st floor. There are 5 restaurants and many bars. Our 3 butlers did everything for us; cut fruits, draw bath, perfume the water, unpack and pack luggage, iron clothes etc.

I returned home to do our laundry and cleaning, and when I rang, no butler appeared! The house cleaning and laundry jolted me to reality. This trip is a dream. I can't believe I have been there.

Continued from p105

Victoria Falls is known as Mosi-oa-Tunya which means "The Smoke that Thunders". The mist from the waterfall can be seen 50 kilometres away on a clear day. The falls straddle the borders of Zambia and Zimbabwe and it can also easily be accessible from Namibia and Botswana. The Victoria Falls are approximately 1,000 metres from the source of the Zambezi. It is 107 kilometres wide, making it the greatest curtain of falling water in the world (Niagara Fall is 1 kilometre wide and 58 metres high). The highest point of the falls creates a "plunge pool" 108 metres deep.

Victoria Falls can be viewed from a number of vantage points. The first six view points focus on the Devil's Cataract and Cataract Island. Then comes the Main Falls and Livingstone Island from which Dr Livingstone first saw the Falls. Following that, are the Horseshoe Falls and Rainbow Falls. Rainbow Falls is the highest falls, which is 108 metres high. The view from the helicopter gives an overall view of the falls and surrounding area; it is most impressive and well worth the extra US \$90.

In the afternoon, we were taken for a sunset cruise on the Zambesi River. The cruise covers twelve kilometers of

the river. The Zambesi River forms the border between Zambia and Zimbabwe. The river is 2,700 kilometres long. We were fortunate to see four elephants making their way across the river. Other activities at Victoria Falls include night safari, bungee jumping from the Victoria Falls Bridge, water sports, and micro-light flights.

Africa is a large continent stretching 8,000 kilometres north to south, with its diverse climate, people and landscapes. Our visit has only touched the surface of this wonderful continent. As all holidays have to come to an end, so until the next visit to Africa, "hakuna matata" (no worries).

References

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- National Museum of Tanzania. Tanzania. The National Museum of Tanzania, 1990.
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Beggar's Chicken

Elaine Chong

The Origin of Beggars Chicken

The reason why Beggar's Chicken is called just that is because a long, long time ago in ancient China, a beggar found and caught a wild chicken. He was hungry and desperate to cook and eat the chicken. There was only one problem – he had no kitchen facilities. He came up with an ingenious plan to cook the chicken using mud, in the ground. He dug a hole, made a fire and covered the chicken in mud as there was no aluminium foil at the time. He then put the chicken in the fire and covered up the hole to let the chicken cook and the juices simmer. To his delight, upon cracking open the mud shell, he found a soft tender delicious chicken. From then on, beggar's chicken became a favourite. Nowadays more spices and seasonings are used. Enjoy this recipe!

Ingredients

- 1.5kg(3lb)chicken
- 3 shallots
- 2.5cm (1") roughly chopped green ginger, peeled and sliced
- 1 tsp sugar
- 3 tblsp soy sauce
- 2 tblsp dry sherry
- 1 tblsp water
- ¼ tsp five spice powder
- 2 tblsp soy sauce, extra
- 2 tblsp oil
- Extra oil

“Clay” Dough:

- 1 kg (2lbs)cooking salt
- 4 cups plain flour
- 1 ½ cups water (more or less)

Be sure to have a hammer ready so you can get at the succulent chicken !

Instructions

Put flour and salt in a bowl, mix well, gradually add water, kneading to a firm dough. More water may be needed but do not have dough too soft as it will be too difficult to handle.

Place two very large sheets of aluminium foil on a flat surface, brush top sheet well with extra oil. Place the chicken onto the foil. In a bowl put shallots, sugar, ginger, soy sauce, sherry, water and five spice powder; mix well. Rub the chook all over with extra soy sauce, then rub with the 2 talbesps of oil, well into the skin. Pull skin at neck end down under the chicken and tuck the wing tips under as well to hold the neck skin in place. The chicken will feel greasy at this stage. Carefully pour soy sauce mixture into the cavity. Secure the rear end with a small skewer or tooth picks. Wrap the foil around the chicken, like a parcel.

Roll out the dough to about 1cm(1/2") thickness so it will completely cover the foil-wrapped chicken, seal edges together, so the chicken is completely encased.

Place in lightly oiled baking dish, making sure there are no holes in the dough (the steam will escape otherwise).

Bake in oven (475-550F / 250-260C) for 1 hour. Reduce heat (325-350F /160-180C) for a further 3 hours. Remove from the oven, break open the dough with the hammer and remove foil from around the chicken.

(The meat will just fall off the bones so chop-sticks will probably be in order).

This fantastic dish will impress, especially when a hammer is sited in the kitchen or on the dinning table!!!

Ferry's good food guide

Ferry Rusli

Shira Nui

247 Springvale Road, Glen Waverley, Vic 3150
Tel: 9886 7755

For lovers of Japanese cuisine, you cannot go past Shira Nui in the vibrant suburb of Glen Waverley. It has been around for more than 4 years and the food is just getting better and better. Chef and owner Hiro Nishikura is ably assisted by his wife Suzy who managed the dining room with the support of knowledgeable and attentive waitressing staff.

The restaurant is small but the food is big in taste, freshness and presentation. Wheelchair access is good and single patron/diner can sit at the sushi bar and enjoy the entertainment as Hiro prepares the sushi/sashimi.

The first 2 pages of the menu are dominated by a selection of sushi and sashimi, which is the main strength of this restaurant. All sushi and sashimi are freshly prepared when they are ordered. All seafood are delivered daily from the sparkling pristine waters of Tasmania & South Australia. If you love sushi, you can opt for the 'Omakase' (ie "leave the menu to the chef") and you will not be disappointed by the array of fresh sushi (both raw/lightly cooked seafood) being served only for patrons sitting at the counter/bar. Different fish are available each day, ranging from hapuka, hiramasa kingfish, mackerel, swordfish to the regular salmon / tuna. Freshwater prawns (ama ebi), uni (sea urchin roe), oysters, hotate (scallops), tako (octopus) and squid are also regularly available. For those who prefer their fish cooked, do not despair as there are many selections of sushi that are made of cooked/grilled seafood—for example the pan-fried salmon nigiri (6 pieces for \$20) is brilliantly prepared and marinated (medium rare), the fish will melt in your mouth. They also served prawn tempura roll (\$14), barbeque beef sushi (\$20) as well as pressed sushi (ie sushi made by being pressed in a little wooden box, turned up square on the plate with grilled eel, marinated mackerel and salmon as the usual ingredients).



The next 2 pages of the menu contained some smallish to medium sized cooked dishes. For those carnivores, you can't go past the garlic lamb cutlets (\$15), they are very juicy, trimmed and tender pieces of marinated lamb (medium rare) served on a bed of salad; the thought of it made me salivate! Gyoza (\$6.50), age dofu (fried tofu \$9), kara age (fried marinated chicken thigh) are entrée size dishes. Other notable cooked dishes include the grilled kingfish head (marinated in salt, \$14) for those who appreciate the best part of the fish, ie the cheek & meat next to the pectoral fins and belly; you will not be disappointed!! Yose nabe (\$25) is also another favourite of mine, a basic Japanese hot pot containing seafood, chicken and beef served with udon noodle; this is served as comfort food in a cold winter's night.

The vegetarian dishes are very good even for a carnivore like me. The spaghetti salad is petit and flavoursome, and the tofu seaweed salad is served with a wasabi dressing that is light and refreshing!! Vegan dishes will be served by the kitchen at your special request.

The dessert selection will not disappoint those with a sweet tooth. There are 3 types of crème brulee (green tea, black sesame and vanilla), cappuccino mousse and my favourite creamcheese crepe (served with black sesame ice cream). There is also a surprise dessert of the day which is usually very good!

The wine list is not extensive but adequate for this restaurant. There are a few selections of hot or cold sake (rice wine, imported or locally made), plum wine as well as Japanese beers (Asahi, Sapporo etc) and soft drinks.



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For those who can only hang around lunch time, there is a special lunch menu which is value for money. There are sushi/sashimi lunch set selections as well cooked dishes such as soba with prawn tempura, momoyaki chicken (pan fried chicken with garlic soy cause) and braised pork with rice. My favourite is the chirashi zushi lunch special set made up of a bowl of rice that has been mixed with shitake mushroom, omelette & sweet ginger and topped with a selection of raw fish (kingfish, salmon, tuna, octopus & cooked prawn/eel) as well as a cup of chawan mushi(savoury egg custard with chicken), miso soup and an appetiser, all for \$18.50.

Enough said, try it for yourself and give me your feedback!!

Itata Kimas!

Price guide:

Omakase \$60 to \$100 per person (excluding drinks)

Sushi (mixed selection) \$18 (entrée), \$24 (main)

Cooked dishes \$6.50 - \$30

Vegetarian \$6.50 - \$11

Dessert \$9 - \$12

Lunch set \$9 - \$18.50

Seatings: 50 plus 16 at counter/sushi bar

Parking: large public parking space at Glen shopping centre.



Australian Chinese Medical Association (Vic.) Inc.

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Application Form

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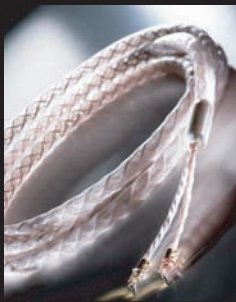
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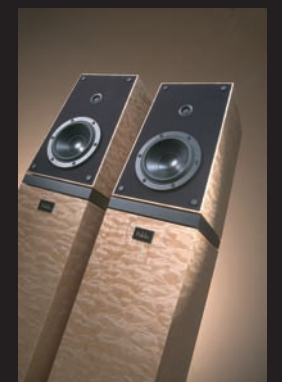
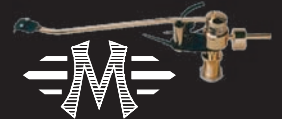
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Benefits of AMA membership

William Glasson

Life as a doctor is just that – a lifestyle choice. None of us look on our careers as merely a job. It's a vocation filled with an increasing number of challenges in a diverse range of areas.

As President of the Australian Medical Association (AMA) I had the great privilege of representing the country's medical profession by trying to get better and fairer outcomes for both the community and the medicos, by working with and lobbying State and Federal governments. Some might say 'battling' the governments. It was never a job for the faint hearted.

After finishing my term in May 2005, I was finally able to catch my breath and look back on two years of achievements, frustrations, policy wins, and a general whirl wind of activity.

I have absolutely no doubt that the effort was worth it.

But I'm equally convinced that it will only be a continuous and ongoing effort from the AMA that makes sure the medical profession gains, or retains, advances in a wide variety of areas.

Which leads to the question – *'why should you be a member of the AMA?'*

As the country's peak medico-political lobbying body, the AMA works hard for you, so that you can get on with what you do best - practice medicine.

As an ophthalmologist, I'm well qualified to say that the AMA is the eyes (and ears) of the medical profession. Most importantly, it is also the professions' most powerful voice – in the eyes of our peers, the community, media and government. While many members of the Australian Chinese Medical Association are already active within the AMA, only by you joining can the AMA keep its membership diverse and fully representational.

The AMA has a national membership of well over 27,000 and is the largest medical organisation in Australia. We represent all disciplines and membership is open to any medical practitioner holding current registration to practice.

The AMA always keeps its goals at the forefront of our representative efforts; we

- promote ethical behaviour by the medical profession and protect the integrity and independence of the doctor/patient relationship;
- advance the public health;
- protect the academic, professional and economic independence and the well being of medical practitioners; and
- preserve and protect the political, legal and industrial interests of medical practitioners.

Doing all that in a world of shifting goal-posts and competing political agendas is not easy. But the AMA does it by using a range of different methods, including:

- consulting, co-operating and communicating with all areas of the medical profession;
- acting as the principal co-ordinating and lobbying body for the medical profession;
- providing a forum for the different opinions amongst medical practitioners and seeking a unified position;
- maintaining high clinical and ethical standards in medical practice; and
- communicating with the community.

Of course, being prepared to roll the sleeves up and having the occasional toe-to-toe with the government doesn't hurt either!

A range of professional benefits also comes with membership. The AMA provides assistance with troublesome areas

like industrial relations, legal advice, business and Practice management.

And we wouldn't be human if we didn't enjoy the commercial offers that come with our membership card. A range of Corporate Partners who provide great value and membership discounts on travel, insurance, finance and loans, accounting, leasing and hiring services – to name a few – is more than enough incentive to hand over the membership fee.

The cliché about 'strength in numbers' rings no truer than in the medical profession. Being able to identify with a group, find ways to work together, and get results as a team is important to almost everyone.

You believe in that philosophy, otherwise you wouldn't be part of the Australian Chinese Medical Association.

Taking the next step and joining the AMA is a guaranteed way to ensure the professions - and therefore your interests – are advanced.

A handwritten signature in cursive script, appearing to read "Bill Glasson".

Bill Glasson



Advancing the medical profession.

2 0 0 6

Method of Payment

TAX INVOICE WHEN PAID

Select preferred payment option

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- Telephone (03) 9280 8722 or 1800 810 451 (Country Free Call) with your credit card details ready.
- Cheque payable to Australian Medical Association Victoria Limited.
- Credit Card (select one).

I authorise AMA Victoria to debit my:

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CARD NO

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Please complete application and payment sections in full and return to AMA Victoria in the reply paid envelope enclosed.

Full details of how to access the support and benefits are contained in the AMA Victoria new member kit which will be mailed to you shortly along with your receipt and membership card.

Membership Application

... CONTINUED

Languages

Please list any languages spoken, other than English. (Max of 6)

I wish to promote my practice to the public and colleagues through Doctor Search on the AMA Victoria website.

Yes No

Code of Ethics

For receipt of a certificate, promoting your membership and commitment to the AMA Code of Ethics sign here.



The Code of Ethics is available on the web at www.amavic.com.au

A copy of the AMA Victoria constitution is available at www.amavic.com.au

ASMOF Membership

As an additional benefit for members who are full time medical officers employed by a public hospital, AMA Victoria has a conjoint membership arrangement with the Victorian Branch of the Australian Salaried Medical Officers Federation (ASMOF). ASMOF is the principal federally registered union representing medical officers in public hospitals. Under this arrangement, membership is provided without further subscription costs to full time Hospital Medical Officers and Salaried Medical Officers who are financial members of AMA Victoria at 31 March each year.

As with all registered unions, as an ASMOF member you may become liable for levies, including fees and fines in accordance with its rules. The rules of ASMOF are available at www.asmo.org.au

If you wish to resign your membership of ASMOF you must write to the Secretary, ASMOF Victorian Branch, at 239 Royal Parade, Parkville, 3052.

Non-AMA members can join ASMOF however they may be required to pay a subscription fee and may do so by contacting ASMOF at the above address.

If you are a full time medical officer and do not wish to become an ASMOF member, please tick the box.

Commercial Benefits

AMA Victoria members can gain significant savings by using the services of our commercial partners.

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- Financial planning and advice
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- Debt collection
- General legal advice

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- Electrical goods
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Commission statement

AMA Victoria and its related entities at times receive non-subscription income through commissions paid by service providers that provide commercial benefits to members. Through this, we can provide additional resources for core activities and keep members' subscriptions to a minimum.

Membership Fees by Category

(incl 10% GST)

| | DIRECT/DEBIT* | ANNUAL |
|--|---------------|---------|
| | \$/MTH | \$/YR |
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| GP5 Part time 11 - 25 hours / week | 52.95 | 635.40 |
| GP2 Part time 1 - 10 hours / week | 22.75 | 273.00 |
| GP6R General Practice Registrar | 61.50 | 738.00 |
| SP Specialist Practice | 86.60 | 1039.20 |
| SPP5 Part time 11 - 25 hours / week | 53.75 | 645.00 |
| SPP2 Part time 1 - 10 hours / week | 23.40 | 280.80 |
| Hospital Medical Officer | | |
| DIT1 Year 1 (intern) | 20.70 | 248.40 |
| DIT2 Year 2 after graduation | 30.10 | 361.20 |
| DIT3 Year 3 after graduation | 40.10 | 481.20 |
| DIT4 Year 4 after graduation | 52.35 | 628.20 |
| DIT5 Year 5 & thereafter (incl. registrars) | 61.50 | 738.00 |
| Salaried Medical Officer/Specialist | | |
| SMD No Private Practice Rights | 80.90 | 970.80 |
| SMOP Private Practice Rights | 86.60 | 1039.20 |
| Academic Staff | | |
| AS No Private Practice Rights | 57.25 | 687.00 |
| ASP Private Practice Rights | 63.60 | 763.20 |
| OS Overseas | 37.30 | 447.60 |
| PG Post Graduate | 33.30 | 399.60 |
| 70+ Over 70 in Practice | 33.30 | 399.60 |
| MAT Maternity Leave | 22.75 | 273.00 |
| RET Retired from Practice | 21.75 | 261.00 |

Membership is open to medical practitioners registered to practise in Victoria. AMA subscriptions are fully tax deductible. Payment includes membership of AMA Victoria and the Federal AMA.

Joint spouse discounts are available to member couples, discounted at approx. 25% off each fee. *Direct Debit per month.

Your choice of category should reflect your total work commitment from all health industry related activities. Call (03) 9280 8722 to join by phone or discuss joining. Pro-rata rates apply from March.

Membership Application

AMA Victoria manages your personal information in accordance with our obligations under the Privacy Act 1988. For details of our Privacy Policy see our website or call our Privacy Officer on (03) 9280 8722.

I, _____

GIVEN NAME/S _____ SURNAME (BLOCK LETTERS) _____

Hereby apply to be elected a member of the Australian Medical Association Victoria and the Federal AMA.

TITLE (SIR, PROFESSOR, DOCTOR, ETC) _____

REGISTRATION NUMBER _____

REGISTERED NAME _____
(NAME UNDER WHICH YOU ARE REGISTERED AS A PRACTITIONER)

SURNAME _____

GIVEN NAME/S _____

MALE FEMALE DATE OF BIRTH / /

Have you previously been an AMA member? Yes No

YEAR _____ STATE _____

PLACE OF GRADUATION _____ YEAR _____

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List principal practice address first, maximum 2 addresses

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WEBSITE: www.amavic.com.au
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Practice Address 2

POSTCODE _____

TELEPHONE _____ FACSIMILE _____

EMAIL _____

Correspondence should be addressed to:

Private address Practice address 1 Practice address 2

Married to (Complete only if spouse is an AMA member)

GIVEN NAME/S _____ SURNAME (BLOCK LETTERS) _____

Specialty / Specialities or Special areas of interest

(Please nominate which this is)

Specialty/Specialities or Special interests (max 3)

1 _____

2 _____

3 _____

For AMA voting purposes choose one of the following as your specialisation (Craft) group:

- Anaesthetics Dermatology Emergency Medicine
 General Practice Obstetrics & Gynaecology
 Ophthalmology Orthopaedic Surgery
 Paediatrics Pathology Physician
 Psychiatry Radiology Surgery

In addition, if you currently work in one of the following areas please make a further choice:

- Doctor in Training Salaried Doctor Visiting Medical Officer

| SURNAME | GIVEN NAME |
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| SURNAME | GIVEN NAME |
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| Chan | Dr | William |
| Cheong | Dr | Yew Mun |
| Lim | Prof | Yean Leng |

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Goh Dr T Hoe

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| | | |
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| Tjandra | A/Prof | Joe Janwar |

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| Oral & Maxillofacial Surgery | |
| Ching | Mr Martin |
| Hing | Mr Richard |

| SURNAME | GIVEN NAME |
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|---------|------------|

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| Lim | Dr Boon Hui |

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| SURNAME | GIVEN NAME |
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| Chan | Mr Yee Kar |
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Australia Chinese Medical Association of Victoria

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1st January 2006 to 31st December 2006

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I agree to abide by the rules and regulations of the **Australian Chinese Medical Association (Vic) Inc.**

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PLEASE NOTE: This form is for NEW MEMBERS ONLY. Existing members have been sent individual tax invoices. Any changes in details for the membership Directory should be faxed to the Editor on 9899 6389.



Australian Chinese Medical Association (Vic.) Inc.

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Notes:

Acknowledgements

The Editor thanks our members, contributors from overseas and interstate, for sharing their work experiences in their medical fields of interest and submission of entertaining articles.

To our sponsors who remain staunch supporters of Qi, I thank you for your financial contribution. In the present financial climate, we are aware of constrains and hope that future prosperity will encourage those who have not requested advertising this year, would do so next year.

To all my friends and members of the ACMAV, I thank you for your encouragement and support. I will hand over editorship to a younger member whom I am confident will carry on the tradition of this highly regarded publication.

Special thanks is given to Professor Martin B Van Der Weyden for premission to reproduce MJA editorials (From Editor's Desk) - articles that titillate our readers.

I thank the co-editor Elaine Chong for her assistance and Professor Eng Seong Tan for agreeing to write the caption for the cover of this year's publication.

I am indebted to Belinda Chen at Ivy Printing for her patience and for being so accommodating.



Siew-Khin Tang
Editor