Editor: Siew-Khin (Happy) Tang

Co-Editor: Adrian Mar

Qi 氣 2006

Annual Publication of the

Australian Chinese Medical Association (Vic.) Inc.

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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天向燕畫
上往兒如
人未展花
間來翅鮮

Fresh as a flower
Free as a bird
Life looks to the future
Heaven surrounds the Earth

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Editorial

Time passes so quickly and we often wonder if we have achieved all we'd intended from our "must do" list from the year before! In 2006 the Annual Conference was the main event, with overwhelming support from our members, registrants, speakers and sponsors, making this the most successful medical gathering of the ACMAV to date.

Our overseas aid projects continue, with our major aid program involving plastic and reconstructive surgery to young patients from Vietnam, who would otherwise not have the chance to receive these life-changing operations. With a financial contribution from the Lions Club of Melbourne Chinese, the services of plastic surgeons who give of their valuable time without hesitation, and the help of hospitals such as the St John of God hospital in Geelong, such projects are being successfully completed even as we go to print. It is appropriate that we acknowledge Dr Theong Low as this year's Distinguished Personality, in recognition of his enormous contribution and ongoing work in helping ACMAV to continue this important charitable work.

This year the medical section includes a number of topics of current interest. As always, they have been chosen in the hope of assisting our members in their daily encounters with patient needs and requests. The issues surrounding 'Stem cell research' and 'Surrogacy' are currently being actively debated in Parliament and by the legal profession. We all await the outcome of these discussions with interest.

The Travelogue and culinary contributions in this year's edition continue to whet our appetite and conjure imaginations we are yet to experience. I hope you enjoy reading the Kaleidoscope section to find out more about our members' interests.

A new segment called "Simply Chinese" has been added. This is an attempt to remind ourselves of the rich heritage and Asian characteristics we carry with us, even in our busy lives. This section is also an invitation to our friends and colleagues to contribute their own reflections on aspects of our customs and language.

I am humbled by the many encouraging words from the committee and members throughout the year. My hope is for 'Qi' to grow from strength to strength, with members and colleagues encouraging an ever widening circle of friends to read this publication and in so doing to encourage membership to the ACMAV.

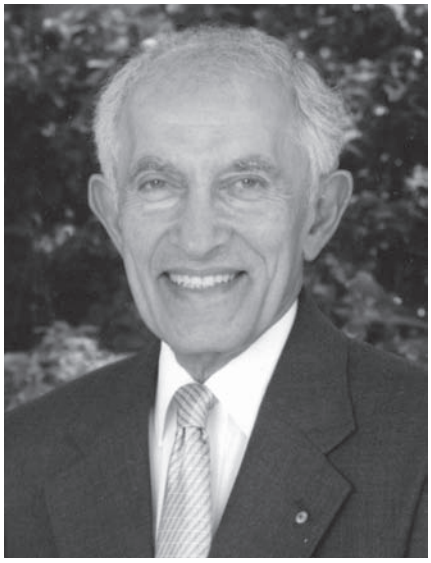
My hope is for the younger members of our association to take up positions on the Committee and to consider the role of Editor, a position I am now relinquishing after three years.

" Knowledge is the source of wisdom, (知識 – 智慧源泉)

Knowledge is without boundaries." (知識 – 遼無邊界)

Siew-Khin (Happy) Tang

Foreword



I am delighted to write this Foreword to the annual publication of your Association. The publication provides succinct summaries on a wide array of medical subjects which are of interest to health professionals. Such articles help to inform General Practitioners and Specialists alike, often on topics that are outside their field. The articles provide a simple way of keeping up with the very wide literature that confronts medical practitioners and allied health professionals today.

The speed with which knowledge is accumulating in our discipline is truly remarkable. With the rapid developments in biology that are taking place through cutting edge research, many aspects of our medical practice will change dramatically as the results of these investigations are turned into practical approaches that will assist us in treating our patients.

The very wide applications that will flow from the human genome projects are only just beginning to be tapped. There is every possibility that within ten years, patients may, within a week, have provision of their entire genome thus identifying their potential to develop a variety of preventable medical illnesses. Clearly such studies would not be practicable without dramatic advances in the technology that underpins DNA analysis and the evaluation of the vast amount of information that can flow from DNA sequences.

It is for this reason that in my previous profession, I have continually emphasised to students undertaking a medical course, that they must prepare themselves for a lifetime approach to learning. There is no doubt that those of us who are more advanced in our careers also need to develop that philosophy. Articles such as those in this volume will assist that lifelong learning. I wish you good reading.

Emeritus Professor
David de Kretser AC
Governor of Victoria

President's Report

It is my pleasure to report on the activities and achievements of the Association over the last 12 months, from May 2006 to April 2007. The year of the Dog turned out to be a very busy and successful year for our Association in terms of our education seminars and community and medical aid projects.

Educational Program

The dinner-seminar program has been the backbone activity of our Association, providing an excellent opportunity for learning and social interaction between members in a relaxing and enjoyable environment. Over the last twelve months, we were able to run a meeting almost every month which represented exceptional value for money to our membership. Importantly, the educational value and quality of the presentations have all been of exceptionally high standard as well as being relevant to our members. We were also able to secure sponsorship which allowed us to conduct these meetings in classy venues serving gourmet menus for the enjoyment of our members. The highlight of our Educational Program was the Annual Conference on "Body and Mind" which was highly successful and greatly enjoyed by all those in attendance. Dr Jun Yang and her organizing committee are to be commended for their great organizational skills and tireless effort.

Charitable and Medical Aid Activities

The Association continued to maintain its strong commitment in supporting community and humanitarian projects. We were involved in Project Africa and Project Mongolia through the effort of our past President, Dr Benny Foo. The medical assistance project involving the life transforming surgery for a burns victim from Vietnam, Ms Hong Hanh Luong, has been championed by our dedicated committee member, Dr Theong Low. We have also been active in delivering health education talks to the Chinese community through the effort of Dr Lawrence Wu and his colleagues. All these worthy activities have gained recognition and publicity in the media for our Association.

Communication with members

Keeping members informed and engaged in the activities of the Association is absolutely crucial to the wellbeing and longevity of the organisation, and to this end the Committee had been working hard to attain this goal. Dr Adrian Mar, our Vice President and Editor of the ACMAV Newsletter, is to be acknowledged for his super effort in designing our quarterly newsletter, now called *Meridian* and the electronic bulletin, *e-News*. Our yearly publication, *Qi* Magazine is another important trade-mark of our Association which serves to highlight the activities, achievements and talents in the Association. We are greatly indebted to Dr Happy Tang, who has been the Chief Editor of Qi for many years, for her reliability, dedication and tireless effort in sustaining this official yearbook. Our Website (at www.acmav.org) is an important channel of mass communication with members and the world! Dr Erwin Loh, our Secretary and in-house medico-legal expert is solely responsible for running it and we are all very appreciative of his expertise and talent.

Collaboration with other Societies

For our Association to grow into a robust professional organization we have to interact with and develop links with other like-minded societies. To this end we joined with the Lions Club of Melbourne Chinese in their Annual Charity Ball held in November which was successful in raising a significant amount of funds for Project Vietnam. We were also invited by the Australian Chinese Association for Biomedical Sciences Inc. to participate in their inaugural Research Conference held in February 2007 in Melbourne. As a good will gesture, we invited the ACABS President and his colleague to our November educational seminar, and ACMAV also sponsored a biomedical researcher from China to attend the ACABS Conference.

ACMAV House Project

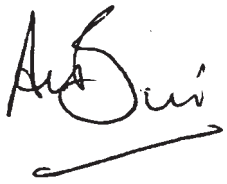
The ACMAV House is a valuable asset of the Association and with the recent finding of general deterioration of the building that will require repair work to be done fairly soon, a Sub-committee has been set up to examine the various options. Dr Andrew Lim has been appointed to chair this sub-committee which will carefully consider this complex issue over the next few months before reporting back to the Committee and ultimately to the members.

Social and Sporting Activities

The annual Golf and Tennis Tournaments have become traditions of the Association. Both events have a strong and avid following among our membership and they provide opportunities for social interaction and foster harmony and cohesion within the Association. To Dr Karen Lee, who has great organizational skills, we are indebted for her tireless effort in setting up the Annual Golf Day. We also want to thank Dr Trevor Lau-Gooey for organizing the Annual Tennis Tournament.

Further Acknowledgements

Finally, I would like to acknowledge the dedication, contribution and hard work of all the Committee members - Adrian Mar, Erwin Loh, Lawrence Wu, Frank Thien, Jun Yang, Nicole Yap, Theong Low, Ferry Rusli, Leona Yip and James Chiu. I have enjoyed working with this group of talented people and I have also learned a few things from them. I appreciate their assistance, friendship and sense of humour. I wish to warmly thank them all for their sterling effort. I would also like express my appreciation to our members for their encouragement and support.



Andrew Bui

Australian Chinese Medical Association (Vic.) Inc.

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Jun Yang

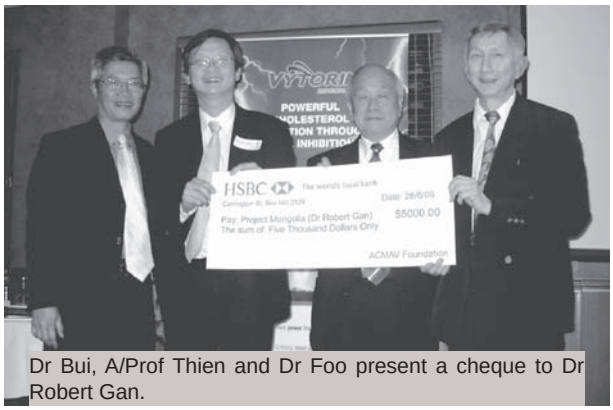
Nicole Yap

Siew-Khin
(Happy) Tang
Editor

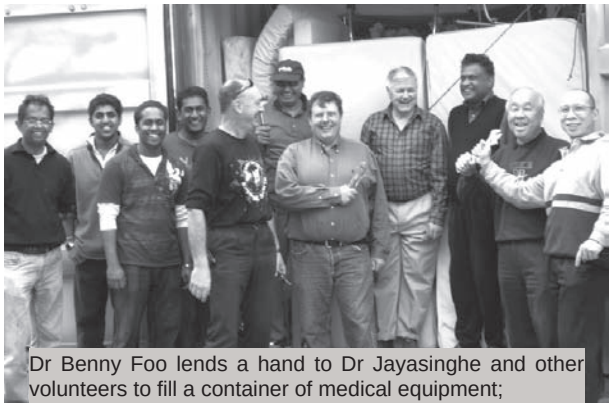
Community Projects: near and far, great and small

It has now been several years since the ACMAV began to introduce into its agenda a number of community based projects. While the overall direction of these efforts is being adjusted and evaluated all the time, the overriding objective of offering assistance to those in need in the community setting has remained firm.

The notion of "community" has extended from the local Chinese population of Melbourne to those in need from within the wider international community. At the local level, Dr Lawrence Wu continues to coordinate a series of health talks provided to the Chinese Elderly Citizens Club in Box Hill. These informal presentations have been warmly appreciated by this group of seniors, and it is hoped that an extension of this initiative may offer a larger audience access to important health messages delivered in Chinese.



Dr Bui, A/Prof Thien and Dr Foo present a cheque to Dr Robert Gan.


Dr Benny Foo lends a hand to Dr Jayasinghe and other volunteers to fill a container of medical equipment;


hospital beds and other pieces of equipment bound for a hospital in Sri Lanka;

The ACMAV's international projects have been driven by the hard work and personal commitment of two members in particular: Drs Benny Foo and Theong Low. The Committee is grateful for their experience and vision in guiding the ACMAV forward in its endeavours.

Dr Foo's contacts with health professionals and charitable organizations outside of the ACMAV has given the Association the opportunity to offer support to a number of worthwhile programs. The most recent of these involved a donation to assist the delivery of much needed medical equipment to Sri Lanka. This project was overseen by the Rotary Club of Templestowe.

Another project supported by ACMAV has been the Mongolian Aid Trust Fund. The Committee was impressed by the dedication of Dr Robert Gan, a dentist who has responded to the great need for basic medical services in the remote communities of Outer Mongolia. After delivering a memorable presentation at the June dinner seminar, Dr Foo, together with Immediate Past President A/Prof Thien and President Mr Bui, presented Dr Gan with a cheque for $5000. A report by Dr Gan of this aid project appears on page 66.

While the role of the ACMAV will never be as a fund-raising entity, its membership should feel proud in the knowledge that the Association has co-ordinated overseas "mercy flights" to Australia of the type normally conducted by large charitable organizations. Largely through the efforts of Dr Theong Low, ACMAV has now successfully managed to bring to Melbourne three patients with severe deformities who would not otherwise have

had the chance to receive major life-changing surgery. Each of these cases has presented enormous challenges, both logistic and financial. Through personal and professional connections cultivated over years of such work, Dr Low has, on behalf of the ACMAV, managed to draw together teams of surgeons and other doctors, with the support of hospital administrators, corporate and community sponsors and members of the local Vietnamese community, who have all given generously of their time in a truly remarkable effort to bring hope to individuals in desperate need.

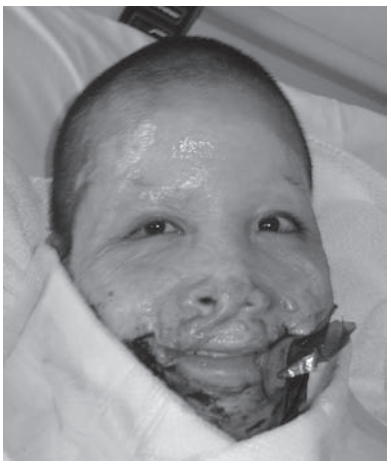
Thus our own Project Vietnam has enabled a girl to have surgery to remove a large mid-facial encephalocoele, and a boy with Apert's syndrome to come to Melbourne for corrective craniofacial surgery. Both of these operations have been performed at the Royal Children's Hospital. Currently a young woman from Vietnam is awaiting the first of a number of surgical procedures to relieve contractures suffered as a result of horrific petrol burns to her face, chest and arms (see below).

In a wonderful example of how charitable deeds bring opportunities for further good deeds, the ACMAV was approached last year by the Lions Club of Melbourne Chinese, seeking a project as the focus for their main fund raising event, the Annual Charity Ball. Not only did this event raise the $18,000 needed to enable the child with Apert's syndrome to have his operation, but the convenor of the Annual Charity Ball, Mr Paul Tjioe, has informed the Committee that his Lions Club has decided to also dedicate this year's ball towards raising money for the ACMAV to bring another child to Melbourne for corrective surgery. This collaboration will allow such valuable work to continue, and has been an inspiration to many, including ACMA colleagues from interstate.

The formation of the ACMAV Foundation has been important in providing a body through which donations can be received and then directed towards these and other charitable projects in the future.

The ACMAV Committee calls on its members to participate in and support these activities. Anyone who would like to take part in these projects should contact the ACMAV Secretary. Any ideas or suggestions would also be welcome.

Adrian Mar



Ms Hong Hanh Luong (pictured left, after her first successful operation) sustained horrific injuries following a petrol burn to her head, trunk and arms 2 years ago. Her neck was fused to her chest, and both arms are fused to her lateral chest wall. Both of her hands were severely contracted, allowing no function at all. Since the tragic event, she has been cared for in a nunnery in the hills of central Vietnam.

As a part of Project Vietnam, ACMAV is sponsoring Ms Luong's visit to Melbourne for a series of surgical procedures. Mr Ian Holten, a plastic surgeon in Geelong, agreed to perform the operations at St John of God Hospital, which commenced in early September. Mr Stephen Roberts, CEO of the hospital, agreed to provide all hospital facilities free of charge. Mr Holten feels that at least six operations will be required over a 6 month period. Ms Luong has been in Melbourne for a few weeks, and is being cared for by a family in Braybrook, organized by the Venerable Thich Phuoc Tan of the Quang Minh Temple in Braybrook. She made a brief visit to the Annual Conference Dinner, where she was accompanied by the family who first located her in Vietnam.

Tai Chi lesson with Mr Boon Hong;

ACMAV Annual Scientific Conference 2006 — "Body and Mind"

Many bodies and minds were gathered at The Novotel in Glen Waverley on the 13th August 2006 for the annual ACMAV conference. It was a beautiful sunny Sunday outside, but it was just as warm and "happening" on the inside!

The minds of the 96 conference registrants were nourished by excellent presentations given by Professor Littlejohn (fibromyalgia), Dr Duncan (opioid therapy), Dr Brown (dementia), Dr Phan (TIA) and Dr Worsnop (COPD). The importance of looking after doctors' health was emphasized by Dr Warhaft and Dr Tippett, and appropriately reinforced by the Tai Chi session led by Mr Hong. The sight of over 90 doctors practicing Tai Chi in their suits and heels was a delight! The panel discussion on Depression in Primary Care was well led by Dr Tang, with excellent contribution from panel members including Dr Chia, A/Prof Wong, Dr Tan and Dr Yap.

The stomachs of the attendees were also well nourished throughout the day, concluding with a sumptuous feast at Tai Pan Restaurant. The eight course banquet menu was thoughtfully designed by Charles, the owner of Tai Pan, to reflect the "Yin and Yang" qualities of Chinese herbs and cooking styles.

Conference registrants also had the privilege of meeting Ms Hong-Hang, a burns patient from Vietnam, at the dinner. She has been sponsored by ACMAV and other contacts of Dr Theong Low, to receive corrective surgery in Geelong. An impressive $7000 was raised for her travel and medical expenses at the conference dinner.

The ACMAV would like to thank all the conference registrants for supporting our association and those who worked hard in the organization of the conference, including Dr Mee Yoke Ling, A/Prof Frank Thien and Dr Happy Tang. The efforts of all the committee members are also most appreciated.

Let's now look forward to the bigger conference in 2007!

Jun Yang

Conference Committee: A/Prof Frank Thien, Dr Happy Tang, Dr Mee-Yoke Ling, Dr Jun Yang;

Depression Panel Discussion: Dr Keong Yap, A/Prof Michael Wong, Dr Meileen Tan;

Prof. Geoff Littlejohn at the lectern;

Audience at Novotel Glen Waverley;

One day in September …

… extreme golf as typhoon conditions hit ACMAV Annual Golf Day!

It was a memborable (certainly weatherwise!) ACMAV Annual Golf Day held at The Dunes Golf Links, Mornington Peninsula on Sunday 24th September 2006. Even the most intrepid golfers were forced to abandon play at the 12th hole when the worst weather for the year managed to unleash its full force midway into our golf tournament. Our ACMAV and Dorevitch banners were nearly blown off the practice putting green, and there was some concern for the stunning BMW M5 on display provided by Menere's near the first tee.

Gale force winds brought drenching horizontal rain and hail with the temperature dropping 10 degrees within an hour. For a golf course known to expose players to the elements – this was extreme golf – not helped by the wind tunnelling effects created by The Cups terrain. Some joked about using the putter for the entire round as all airborne balls were at the mercy of the fierce winds but there was also no shelter from winds playing havoc on the putting greens. Frozen players were rescued by the Course Marshall and eventually all rain-soaked players returned to the comfort of the Clubhouse.

Live weather radar updates suggested that another band of showers would reach us within an hour. After a hot shower and warming up by the fireplace with a glass of red or hot chocolate and a hot meal the vast majority were comfortable and settled and not game enough to venture out again. This was a challenge in awarding prizes, not least because everyone's scorecards were so soaked that they were falling apart and could no longer be written on. It was decided to base the tournament results on the first 9 holes. Anyone who was game enough to play that day deserved to come away with some prizes.

Final Results: Individual stableford

17	Yee Kar CHAN (23, Yarra Yarra GC)
16	Ching Ling HUANG (13, Heidelberg GC)
15	Khai MARK (19, Sandhurst GC)
14	Vich KEYURAGGUL (25, Sandhurst GC)
14	Victor KUAY (19, Cranbourne GC)
14	James WONG (13, Shepparton/Green Acres GC)
13	Steve CHENG (20, Sandhurst GC)
13	Richard SANDERS (27, no home GC)
12	Phil KOSTAS (27, no home GC)
12	Yew Chai LOH (26, Green Acres GC)
12	Weng-Ong (Wayne) TAN (19, Sandhurst GC)
12	Michael YII (21, Green Acres GC)
11	Gilbert CHUAH (21, Kingston Links GC)
11	Richard HING (15, Eastern GC)
10	John CHIN (23, Sandhurst GC)
10	Mark DENNISTON (26, Huntingdale GC)
10	Jenny LIM (37, Sandhurst GC)
10	Lance LIU (27, Kew GC)
9	Anthony POON (16, Moonah Links GC)
7	Kong Lam (Steven) CHAN (16, Spring Valley GC)
4	Siew Keng CHAN (35, Sandhurst GC)
2	Nicole YAP (38, Heritage GC)
-	Shinichiro (Shin) SAKATA [incomplete] (27, Singapore Island GC)
-	Jasper TIONG [unable to attend] (15, no home GC)

4BBB stableford

22	Steve CHENG & Victor KUAY
19	Yee Kar CHAN & Khai MARK
19	Ching Ling HUANG & Phil KOSTAS
18	Yew Chai LOH & James WONG
17	Richard HING & Richard SANDERS
16	Mark DENNISTON & Michael YII
15	John CHIN & Weng-Ong (Wayne) TAN
14	Lance LIU & Anthony POON
13	Vich KEYURAGGUL & Jenny LIM
12	Kong Lam (Steven) CHAN & Gilbert CHUAH
5	Siew Keng CHAN & Nicole YAP
-	Shinichiro (Shin) SAKATA & Jasper TIONG

Our congratulations go to the following players - Yee Kar Chan who took away a carload of prizes including the ACMAV perpetual golf trophy, Individual ACMAV Winner, Open section winner – Best Men's Individual Nett Score and 4BBB Runner-up. Individual ACMAV Runner-up and 4BBB ACMAV Runner-up prizes went to Khai Mark. Steve Cheng and Victor Kuay were the 4BBB ACMAV winning pair. Nearest the pin trophies were awarded to Kong Lam (Steven) Chan (3rd hole) and Jenny Lim (6th hole). Unfortunately due to abandoned play NTP 13th and 17th holes and Longest Men's and Ladies' Drives 18th hole were unable to be awarded this year. Jenny Lim also took out the Open section – Best Ladies' Individual Nett Score. The NAGA encouragement award went to Nicole Yap. Lucky draw prizes went to Anthony Poon ("Luxury weekend for 2" – Dorevitch Pathology), Steve Cheng ("Win a BMW for a weekend" – Menere's BMW Brighton) and Kong Lam

Tennis Tournament

The 13th annual ACMAV doubles tennis tournament was held on 22nd October 2006. The winners were Allan Bong and Yu Long Leow. The runners up were Trevor Gin and Trevor Lau-Gooey. Once again we thank Mayne Health for their generous sponsorship of this tournament.

Trevor Lau-Gooey

(Steven) Chan ("One day golf school for 2" – Croker Academy of Golf). There was something for everyone who attended this special event.

Top: Dr Karen Lee at the prize table.

Right: Dr Yee Kar Chan, with the ACMAV Golf Trophy and a "carload" of prizes!

ACMAV would like to thank the following sponsors and their representatives for their generous support and participation in our Annual Golf Day. They provided many gifts, vouchers and prizes which were very much appreciated and helped to make our golf day so much more special and memorable for all participants. Principal sponsor: Dorevitch Pathology; Other sponsors: Menere's BMW Brighton, Shannons, Croker Academy of Golf, Ocean Spray and GolfWorks.

We would like to thank everyone for their patience and understanding on what turned out to be a very trying day (weatherwise), especially the very professional staff at The Dunes for their valued assistance and experience in helping us to stage our golf day. We hope to see many of you again (golfers and sponsors!) at future ACMAV Annual Golf Days under less weather-challenged conditions.

Karen Lee

Distinguished Personality

Dr Theong Ho Low

Dr Theong Ho Low should have been an architect. In fact, in a sense, that's what he has become. But rather than designing hospitals (as he has done in Malaysia), he has become an architect of hope for dozens of patients with life-crippling diseases. As the co-ordinator of mercy missions to bring children and young adults from Third World countries with debilitating and sometimes life-threatening deformities to have surgery in Australia, he has become an inspiration to many and a minor celebrity within the local Vietnamese community, where he is highly regarded for his charitable work.

By his own admission, Dr Low never wanted to be a doctor. He excelled at mathematics and physics as a school student in Kelang, Malaysia, and envisaged a career as a nuclear scientist, computer programmer or electronic engineer. However there were very few job prospects for such graduates in Malaysia at the time, and "as a matter of desperation" he chose Medicine when the chance came to study in Australia. For overseas students there is always the challenge of adapting to a new culture, in addition to the rigours of study. Theong reflects on his days at Melbourne University as a period of awkward adjustment to a life of independence (away from his parents and four older brothers), finding his way in a foreign land (as he recalls: "The lecturers didn't speak English, they spoke *Australian*. I could never understand what they were saying!").

After a short break from his medical studies to marry his high school sweetheart Sue, Dr Low returned to Melbourne with his new wife to complete his degree and enter his internship at the old Queen Victoria Hospital. He then undertook a course in family medicine which led to a career in General Practice. In the mid 1980's Dr Low bought an existing surgery in Flemington. Aside from a brief interlude as a designer for a new hospital in Malaysia (which showcased another of his natural talents and interests), Theong has managed to build up a busy general practice, with a large proportion of his patients being of Chinese background.

It was soon after starting this practice that Dr Low was invited to be a foundation member of the Rotary Club of Flemington. Through the Club, he took the opportunity to engage in local community activities, and after being appointed Chairman of Community Services, he became involved in numerous projects, including fund raising for the Western Autistic Centre in Ascot Vale. But it was the plight of a child from the Philippines which introduced him to a service which reached out far beyond the confines of inner Melbourne. The child was brought to Australia through the Rotary Overseas Medical Aid for Children* (ROMAC) program, which was formed over 20 years ago by a Rotarian from Bendigo. Its aims were (and still are) to bring children under the age of fifteen from the Asia/Pacific Region to Australia for lifesaving and dignity restoring surgery, where those surgeries are not available in their home country. Theong embraced the concept of ROMAC enthusiastically, progressing to become the first National Medical Director, and then National Operations Director for ROMAC. His hard work and dedication were matched only by that of his surgeon collaborators, and are reflected in the remarkable success of the program under his stewardship. ROMAC provided a suitable platform for his skills as a project manager as well as his knowledge as a doctor.

During his time as Director, a total of more than 50 children with disorders ranging from acute burns, intracranial tumours, orthopaedic deformities to severe congenital heart and cranio-facial deformities were brought out to Melbourne from 17 different countries in the Asia Pacific region. They were treated in all of the major Children's

Dr Theong Low with ACMAV's first successful overseas patient, baby Tuong Van (after her operation) together with her mother.

Hospitals of Melbourne, Sydney, Adelaide, Brisbane and the Gold Coast as well as several private hospitals in many regional areas. One such case, which was widely publicised at the time, was the Bosin Siamese twins from Papua New Guinea, who were successfully separated and are now, according to Theong, thriving well as "two beautiful kids". The joy of seeing a smile return to the faces of patients and their families who had long given up hope, has been its own reward for Theong. It is the practice of medicine in its purest form: the restoration of a broken body and hope for the future with no contract other than that of a special and lasting friendship.

In 2002 Theong was invited to join the ACMAV Committee by then President, Dr Benny Foo, who had decided to expand the Association's activities with a more community based focus. Theong brought to the ACMAV his vast experience, without which an organisation of doctors might (surprisingly) otherwise struggle to bring a patient from a developing country for surgery. Finding a suitable patient, a hospital administrator and staff agreeable to be involved in charity work, organising the long-distance medical assessment, visa requirements and transportation, in addition to locating carer families in Australia who share a language and cultural background with the patient, present a sizeable load of potential logistical nightmares. To date these tasks have been entirely conducted by Theong himself, on behalf of the ACMAV. Furthermore, such projects, although carried through by volunteers, are not without substantial costs, particularly for transportation and hospital care, and through his reputation alone Dr Low has been able to raise funds from community sources. The success of the ACMAV's first case, a young girl requiring repair of a large facial encephalocoele, prompted further donations from individuals and the Lions Club of Melbourne Chinese, allowing for more overseas projects to continue in the future.

The most recent ACMAV patient brought to Melbourne from Vietnam, an unfortunate victim of horrific burns, illustrates the pivotal role played by Dr Low. Since her tragic accident, Ms Hanh Hong had been living in a monastery, hidden from the world and in tremendous discomfort. It was an Australian Vietnamese lady from Adelaide, on hearing of Ms Hong's plight while in Vietnam, who sought to offer help, and it was through hearing of Dr Low's previous work that she located him and sought his assistance. Ms Hong has now had several operations, organised by Dr Low and performed by Mr Ian Holten (a Plastic Surgeon) at the St John of God Hospital in Geelong to restore vital function to her face and body. Just as importantly, she now has a renewed outlook on life and displays a greater self confidence. Although she will forever be limited by her previous scars, she will now have the prospect of enjoying a more fulfilling life.

Although Theong is quick to acknowledge the dedication and generosity of his surgical colleagues, it has been his quiet work behind the scenes which brings forth such remarkable outcomes. The true benefits have not only been to the patients and their families, but through the inspiration that his work has generated in others, there has been a sense that we can all contribute in some way to bringing hope to those whose lives might otherwise be filled only with despair.

ACMAV has provided Dr Low with the opportunity to continue with the tremendous work which he began with ROMAC. In turn, we have been able to witness for ourselves, the devotion he has towards helping this special group of patients. In the role of rebuilding people's lives, Theong Low has been both architect and master builder.

*ROMAC has since changed its name to *Reaching Overseas with Medical Aid for Children*

Adrian Mar

Tribute to Dr Lee Min Yap

Reprinted from the "Alfred Matters" Newsletter, January 2007

Stuart Roberts Gastroenterology Director

It is with deep regret and sadness that we farewell our young and esteemed colleague, Dr Lee Min Yap, who passed away on January 1, 2007 after a short illness.

His untimely passing brought a premature close to the promising career of this talented and dedicated gastroenterologist who quickly established himself as a leader in Melbourne in the area of inflammatory bowel disease.

After graduating in Medicine from the University of Melbourne in 1995, Lee Min undertook training at St Vincent's Hospital. He subsequently undertook advanced training in gastroenterology at Flinders Medical Centre in South Australia under the guidance of Dr Geoff Hebbard and Professor Graeme Young. In 2002 he took up a position at The John Radcliff Infirmary Hospital in Oxford, England, under the supervision of Professor Dereck Jewell, a world authority in the area of inflammatory bowel disease (IBD). During his two-year period there as a Gastroenterology Research Fellow and clinical trial investigator, he was highly productive in both clinical and academic gastroenterology. His work investigating the molecular genetics of inflammatory bowel disease and coeliac disease culminating in his award of Doctorate of Medicine from the University of Melbourne in 2005.

Lee Min returned to Australia in 2004 and joined The Alfred as a Visiting Locum Gastroenterologist. Soon afterwards he established the first IBD Clinic at The Alfred utilizing his clinical and endoscopic skills to foster a coordinated approach to managing patients with IBD. In addition, he undertook clinical research in the area of IBD which included managing a number of clinical trials of new biological therapies including the first phase one trial in IBD in Melbourne. In other key initiatives he was instrumental in setting up the IBD database that has become a focal point in networking with other IBD Units, both within Melbourne and around Australia.

His aptitude, clinical acumen and professionalism saw him appointed to the Gastroenterology senior medical staff in 2006 as a Visiting Consultant Gastroenterologist.

On a personal level, he was a very pleasant and engaging young man who was dedicated and committed to his work, family and friends. He was inclusive in his approach to others and developed excellent relationships with nursing, medical and support staff within the Unit and The Alfred. Outside of work, he was a dedicated husband and father of two. He is survived by his wife, Su-Peing, and two children Elliott and Daniel.

Lee Min will be greatly missed by all of us.

Feature Article

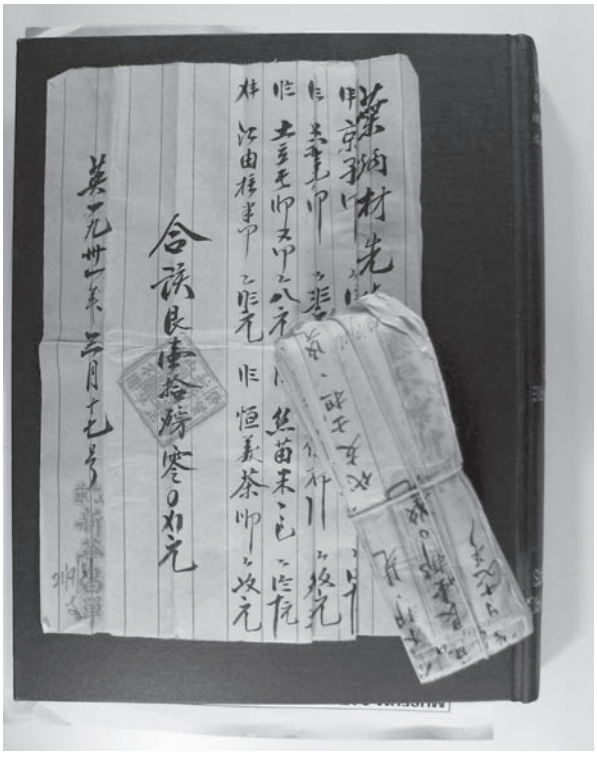
A Story Behind a Gift

Chinese Medical Practice in early rural Gippsland

Ann Brothers
Curator, Medical History Museum

A gift to the Medical Library Special Collections in 1994, from the descendants of Thomas Chong (1877–1950), links the University of Melbourne School of Medicine to the early history of Chinese Traditional Medicine (TCM) in Victoria. The donation consisted of Thomas Chong's professional library of around three hundred medical texts and several hundred paper records, believed to be prescriptions for patients from his Bairnsdale practice dating from the 1920s to 1930s.

Apart from the information they contain, the small, compact bundles, neatly bound together with string, are attractive artefacts. They are recorded by hand in the classical form of Chinese used before the language reforms of the Cultural Revolution.[a]



Herbal prescriptions recorded by Thomas Chong in the traditional Chinese manner, 1920-30. Medical History Museum, University of Melbourne

Thomas Chong, aged about twenty-four years. Photograph courtesy of Dr Dorothy Chong OAM, daughter of Thomas Chong.

The characters are inscribed vertically on the sheet in the traditional manner, using black ink and brush on fine cream rice paper, and indicate the care and pride taken by this professional man. These prescriptions have survived their eighty-odd years in fine condition, and would be clearly legible to the translator of classical Chinese.

The collection of books is of great value and includes some of the ancient classic texts of TCM, and handbooks and texts of the late nineteenth and early twentieth centuries.

This article was first published in Chiron, journal of the University of Melbourne Medical Society, Vol 5, No 4, 2006. Reproduced with permission.

The text books are all printed in Chinese, probably in both the early and modern forms, some with paper covers bound simply in the traditional Chinese manner. A few contain fine woodcuts illustrating the various plants from which herbal preparations were made for specific patient needs, like the early 'herbals' or materia medica of western medicine when pharmaceuticals were also prepared individually by hand. There are examples too, of anatomical texts with illustrations of bones marked with their muscular attachments familiar to the student of western medicine to this day.

Obviously regarded as well qualified by the standards of his time, Thomas's library reflects his lifelong interest in the study of medicine. The books on western medicine, in particular, indicate that he acquainted himself with aspects of western theory and practice.[b]

Thomas Chong's life is best understood within the context of the then hostile attitude of western practitioners towards TCM and the racial prejudice experienced by the Chinese in general in Australia up to the mid-twentieth century. These were difficulties he dealt with in carrying out his work and raising his family.

Thomas's father, Ong Chong, arrived in Australia from Canton as a youth in 1857 and by the 1870s had become a highly successful shipping merchant in Sydney. With his own fleet of sailing, then steam ships, docks and warehouses he was involved with the distribution of goods from around the Pacific to Australia, including the shipping of superphosphates from Nauru.

Whilst the NSW *Chinese Restriction Acts 1888* (and earlier legislation in the 1850s and 60s) had prevented Chinese naturalisation, many Chinese did settle in Australia before the White Australia Policy came into effect in 1901. Applications for naturalisation were made by Chinese wanting to make their farm titles legal, or by those whose business interests were limited by their alien status. Ong, as a man of means, who had no doubt contributed to the commercial growth of the city and colony, was amongst the successful and gained his naturalisation certificate in 1876.

Thomas, the eldest of Ong's children, was born and raised in Sydney, until he was sent to China (Canton), at the age of twelve, to be educated and trained in TCM. His training was conducted under the traditional apprenticeship system (not long abandoned by western doctors for university training), where he worked and studied under a master for a number of years, gaining knowledge of diagnosis and treatment with herbs and other therapeutic products. He graduated from the clinic-dispensary of Huang Jy Shen, at Qi Sha, Zhen Jiang, Guangdong in 1889, not returning to Australia until 1908. During his absence, the White Australia Policy had been enacted and racism, which had surfaced periodically in Australia since the gold rushes, had now become institutionalised. Thomas was subject to its discriminatory powers on re-entering Australia, when he was interrogated and fingerprinted despite being Australian by birth—an indignity he strongly resented. Upon his return to Australia, Thomas commenced practice in Nicholson Street, Melbourne, and married Florence Sam, of Irish-Chinese descent.

Thomas would also have become aware of the uneasy peace that existed between registered doctors and the Chinese 'herbalists' (as they were becoming known). This relationship was evident from time-to-time in the pages of the *Australian Medical Journal* where prosecutions of Chinese using the title of 'doctor' were urged or reported. Cases of malpractice were recorded there too, and comments made on herbalists' thriving businesses, (increasingly expressed in racial terms), which no doubt reinforced the existing prejudice.[c]

Chinese practitioners shared this critical attention with other practitioners —the pharmacists and British herbalists, the unregistered medical practitioners and quacks—who all gave consultations and offered treatment, and who were felt by the medical profession to be in direct competition with themselves. Thomas would have felt the threat of the powerful lobby group of doctors, who in 1905 had seen a bill brought into the Legislative Assembly which, had it been successfully passed, would have prevented anyone but a registered doctor from prescribing or dispensing medicine, or giving medical advice.

On his return from a later trip to China, Thomas was active in the fight against a further bill (in 1925) to amend the *Pharmaceutical Chemists' Act* by limiting the right to dispense medicinal herbs to pharmaceutical chemists. Had herbalists not mounted an intense public campaign, the success of the bill would have put them out of business. Thomas was among forty-six Chinese and European herbalists who proposed their own amendment, supported with a petition signed by 6800 people, to allow some already in practice to continue their business. In the face of such substantial opposition, this bill too was withdrawn.

However, the herbalists' request, that they be made subject to certain training and practical requirements and regis-

tered, was ignored. Had registration of those with professional training been granted, it would have raised the status of and respect for their practice and hastened the reputation of TCM as a complementary medicine rather than its 'alternative' reputation, which lingers to this day.

Thomas appears to have found life in Melbourne unsatisfactory and at intervals made trips into Gippsland before settling in Grant Street, Bairnsdale where he raised his family and ran his practice. His patient record book (held by the family) for the years 1936-38, examined and translated into western medical terminology and English by Dr Qi Li-yi yields interesting information about Thomas Chong's practice.[d] In this twenty-eight month period, he treated 1204 patients including men, women and children. (Readers will no doubt be fascinated to learn that, amongst these patients, on 11 March 1938, was a young Bairnsdale boy by the name of Lance Townsend, who later became a professor in Melbourne's medical school).

Thomas Chong's practice covered 10,800 square kilometers, extending from Sale and Maffra in the west, to Mallacoota in the east, and Delagate in the north. As was the Chinese custom (and unlike his western counterparts), he did not make house calls and many of his patients travelled hundreds of kilometres to be treated. For those unable to travel, he provided an extensive mail order service whereby individually prescribed herbs were posted to them. Patients' names were mostly of British origin, with only a few Chinese, reflecting both the cross-cultural acceptance of his practice and the efficacy of the White Australia Policy and they came from a wide range of socioeconomic backgrounds.

The range of conditions, in order of those most commonly treated in the 1936-38 period, were lower back pain, hepatalgia and headache (around 100 cases each); rheumatic arthrodynia and gastralgia (around forty-five each); irritability, insomnia, enteritis and exanthema (around thirty each); broncho-pneumonia and cough; and pain on urination (around twenty-four cases each). Historian, Morag Loh, points out that some of these conditions were those for which western medicine had a low success rate and others resulted from poor hygiene which greatly improved with raised living standards. In time also, with the advent of the so-called 'wonder drugs' and advances in surgery, some herbal treatments gave way to these more effective solutions, and later, to the growing use of acupuncture as a significant part of TCM practice. Today we find an easier co-existence between the practices of eastern and western medicine, exemplified by patients who visit practitioners of both traditions for different complaints. There are also instances now, of practitioners like Dr Qi, who are registered with qualifications in both spheres of medicine.

Thomas Chong worked seven days a week, averaging twenty-four to thirty consultations a week. Although his income was considerably lower than a local GP of the same period, his workload was less demanding. He did not have the emergency night calls or deliveries to attend, nor the long distances to travel to patients over rough country roads. His children were able to live a modest but comfortable middle class life, and recall having a 'typical Australian country childhood'.

Thomas Chong's papers reveal the successful and stable practice of a medical man who was far from being a marginal figure in health care in the east Gippsland area.

Thomas Chong's Medical Decendants

Thomas Chong's very scholarly life, spent reading and studying when he was not working, provided both example and milieu in which his six children grew up, most of whom pursued careers in medicine or the medical sciences at Melbourne University or the Melbourne College of Pharmacy.

Children of Thomas Chong

- Raymond Victor Chong, born 1917, MB BS (Melb) 1941.
- Albert (Bert) Chong, born 1919, graduated Victorian College of Pharmacy, Melbourne c.1943.
- Dorothy Laurel Chong, born 1922, MB BS (Melb) 1948 (following training as a teacher), was awarded an OAM in 1997 for service to the community and medicine in general practice, particularly in caring for the elderly.
- Norman Chong, born 1925, graduated Victorian College of Pharmacy, Melbourne 1942.
- Gilbert Chong, born c.1926, graduated in Chemical Engineering, RMIT, Melbourne, c.1945.
- Jeffrey Chong, born 1928, graduated BDSc (Melb) 1949.

Grandchildren of Thomas Chong

- John Gooey, MB BS (Melb) 1980, (son of Dorothy Chong) is now an associate professor and surgeon, practicing and lecturing in Otolaryngology in Boston, USA.
- Alyson Christine Lau, MB BS (Monash) 1985, (daughter of Dorothy Chong) is a Melbourne general practitioner.
- Alan Chong, MB BS (Melb) 1977, (son of Albert Chong).

As a postscript to this substantial family tree in medicine, a further generation of the family, two great grandchildren of Thomas are currently undertaking science courses at the University of Melbourne.

Reference: (Endnotes)

a. By 1917 it was recognised that China needed a living 'democratic' medium of expression, and the archaic form of Chinese was abandoned in favour of the Peking vernacular dialect as the national language.

b. When Thomas Chong's children were studying medicine at the University of Melbourne, he always showed an interest in what they were being taught and how they were being trained to use their knowledge in practice. See Morag Loh, 'An Outpost of the Chinese Medical Tradition, *Gippsland Heritage Journal*, 1995, 18:6.

c. See for example AMJ October 1874.

d. For this information and other aspects of this paper I am indebted to Morag Loh and Dr Qi Li-yi of the Academy of Traditional Chinese Medicine, Beijing, and Hammersmith Hospital, who is qualified in both western medicine and TCM. Morag Loh, is an historian who has researched and published on the experience of the Chinese in Victoria, and on the practice of Thomas Chong in particular (see 'Western and Chinese Medicine', *RHSV Journal* 1985, 56(3):38-46, and 'The Practice of Thomas Chong at Bairnsdale', *Gippsland Heritage Journal* 1995, 18:2-7. Both have had the opportunity not only to examine the library, but also Chong's patient records from Aug. 1936 to Dec. 1938, which remain with the family. I am most grateful for the work of these two scholars, who with family members, have provided much of the material which now enhances the significance of the material held in the medical history collections, to the benefit of future researchers.

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澳洲維省中華醫學會

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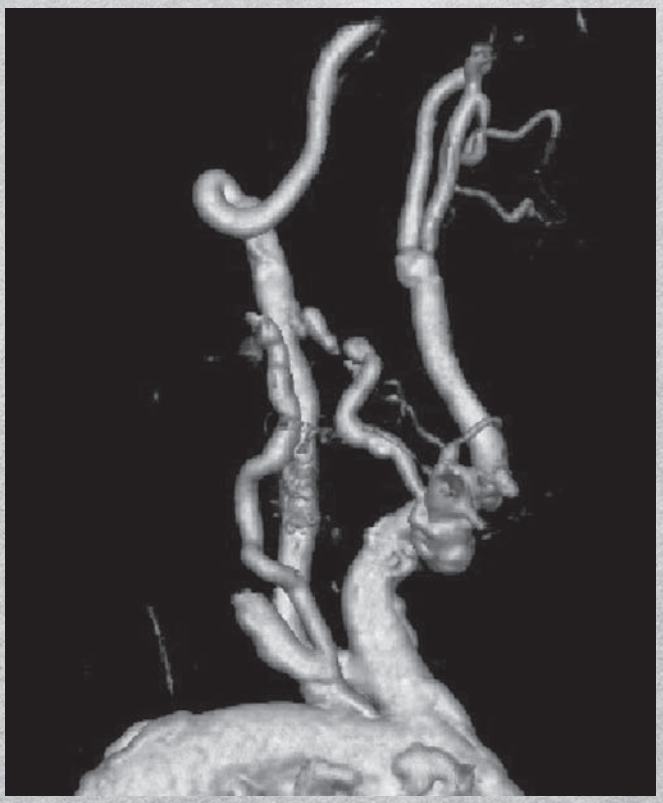

Medical

Welcome locum relief for the overstretched rural obstetric workforce

Anna Maloney

In July 2006 a pilot project to provide rural specialist obstetricians with quality, subsidised locum relief was established. Funded by the Commonwealth government, it is called the "Specialist Obstetrician Locum Scheme" (SOLS). It will run for 15 months and is managed through a Secretariat at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in Melbourne.

How does it work?

The SOLS operates through the Secretariat encouraging all rural obstetricians and rural hospitals that provide maternity care to apply for locum relief and encouraging Fellows of RANZCOG to undertake work as a rural locum. The Secretariat handles requests for locums and arranges placements, registrations, provider numbers and locum travel.

Features:

- 20 rural obstetricians will receive subsidised locum support. Priority is given to applicants in a practice with either one or two specialists. They can be in the public and/or private sector
- the applicant pays a non-refundable administration fee of $550
- the applicant receives a subsidy of $750 per day for 14 days to contribute to the daily locum fee. This is calculated as 50% of the current market rate of $1500 per day
- the project pays for locum travel and travel time to and from the placement;
- the applicant and locum have an optional continuing professional development activity they can participate in which provides valuable points towards their mandatory RANZCOG CPD program.
- Provides guidelines on effective patient handover for SOLS applicants and locums

Anna Maloney BA, LLB (Hons)
SOLS Project Manager

Applicants for locum support may be individual obstetricians, obstetric practices or hospitals in the public and/or private sector. All applicants must be located in rural or regional areas of Australia, and relief can be provided to Area of Need positions which are already filled. Relief is not available to cover unfilled vacancies All locums participating in the pilot must be Fellows of RANZCOG.

The impetus

The plight of a rural medical practitioner is now well known. A review of relevant figures suggests that the rural specialist obstetric and gynaecology workforce is overstretched. The RANZCOG 2006 Workforce Survey indicates 62% of rural specialists are aged 50 years or older, compared with 55% of the urban workforce. Further, 58% of Fellows currently in provincial practice intend leaving within the next 5 years. A prominent reason listed for Fellows leaving provincial practice was professional isolation, and limited professional development opportunities. It is not surprising that 83% of rural obstetricians believed a locum scheme would be an effective mechanism to improve current recruitment and retention levels. There are some encouraging signs. From the RANZCOG 2006 Workforce Survey, 41% of Trainees envisaged working in a provincial city, large town or rural area as opposed to a major urban centre. So a reliable locum service appears an obvious avenue of support that has the potential to improve current recruitment and retention levels.

But it was at a meeting of the Rural Specialist's Group of the Rural Doctors Association of Australia (RDAA) in 2004 where the SOLS project was first given life. That important and highly relevant group identified the shortage of obstetricians and the lack of locum support and services in rural and remote Australia as a priority issue. In collaboration with RANZCOG and the NSW Rural Doctors Network, RDAA approached the Australian Government and funding was provided for a scoping study and the current SOLS pilot.

The results

SOLS commenced in July 2006 and already has positive results. We have received 40 expressions of interest from rural specialists or hospitals applying for locum relief and it has been particularly encouraging that 50 RANZCOG Fellows have expressed interest in providing locum relief.

The first SOLS placement occurred in Kalgoorlie, WA, in November 2006 when an experienced Fellow from Wodonga in Victoria relieved the specialist obstetrician in solo practice in Kalgoorlie.

In economic terms alone, this locum placement presented interesting results. In 14 days the SOLS locum saw 56 patients with pregnancy or labour complications who otherwise would have been transferred by air retrieval to Perth (600kms away) at a cost of $10,000 per patient. Similarly, at a Goulburn (NSW) placement in December 2006, had there been no on-call specialist the unit would have closed, necessitating the transfer of 6 gynaecology and 20 obstetric cases. In what is shaping up as a win-win situation, rural specialists receive quality locum relief and the Australian Government receives excellent value for its money.

SOLS locum placements have also occurred in Warrnambool (VIC), Nowra (NSW) Derby (WA), Port Pirie and Port Augusta (SA), and Gladstone (QLD). Future placements are scheduled to occur in March 2007 for Sale and Wangaratta (VIC), and a second Derby placement (WA). Current SOLS locum vacancies are in Mildura and Hamilton (VIC) and Berri (SA).

The future

It is anticipated that the SOLS pilot will form the basis of a broader ongoing support system. In a pre-budget submission recently provided to the federal government we requested funding to extend the pilot for a further 3 years and to expand it to provide locum relief for all rural specialist obstetricians and rural GP obstetricians. The consistent view of participants in the SOLS pilot is that supporting GP obstetricians is an essential element in ensuring the sustainability of rural obstetric services The rural GP obstetrics workforce is also in need of efficient and cost-effective locum support. At present finding suitably qualified locums who can maintain their obstetric services is a significant problem for GP obstetricians. SOLS will be able to help there, using RANZCOG data bases in the way that has proved successful in recruiting specialist locums.

There are 2,300 RANZCOG Diplomates in Australia (a Diplomate is a GP who has completed and maintains the Diploma of Obstetrics). There are 500 Diplomates located in rural areas. RANZCOG maintains the contact details and membership classifications of all Diplomates. It is anticipated that those practising in urban areas would welcome the opportunity to provide locum relief and develop their obstetric skills. Further, those Diplomates who are unsuccessful in their attempt to enter the specialist trainee program could develop their skills through rural obstetric locum placements.

This is a perfect opportunity for the Australian Government to confirm its commitment to maintaining and improving the access of rural women to quality local obstetric care. Eventually it is hoped that the SOLS model will be transferred to other areas of specialist practice, thus improving access to a wider range of services.

Are you interested?

SOLS continues to call for expressions of interest from applicants who would like to receive locum relief, or to register on the SOLS database as a locum provider. To express interest, make comment, offer suggestions or for any queries, please contact Anna Maloney amaloney@ranzcog.edu.au.

References

1. Workforce Survey 2006 of Fellows and Retired Fellows, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 17 May 2006.

2. The provincial fellows have taken time to inform the community of this situation by participating in the RANZCOG 2006 Workforce Survey. There was close to a 100% response rate from rural practitioners compared with a 69% response rate overall.

Faecal Occult Blood Testing – Why, Who, When and How?

Alan McNeil, Que Lam, Matthew Tallack

Why Screen for Colorectal Cancer?

Mass screening with faecal occult blood testing can reduce deaths from bowel cancer by 15-40%. This is of huge potential importance in countries like Australia where this cancer affects more than 13,000 people each year. There are 36 new diagnoses and 13 deaths from bowel cancer each day. It is the second most common cause of death from cancer after lung cancer and twice as many people die from bowel cancer than from breast or prostate cancer[1]. The peak incidence of this disease is in people over 60 years of age (figure 1) and death tends to occur approximately 10 years after diagnosis whenever this occurs.

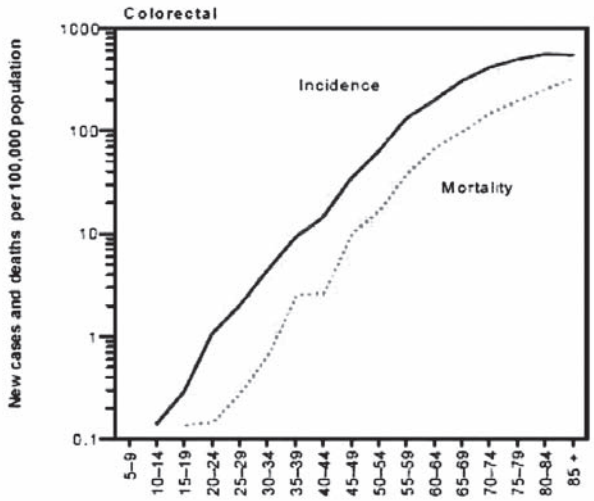

Figure 1. Age-specific incidence and mortality of colorectal cancer in men – figures similar for women (Australian Institute of Health and Welfare with permission)[1].

Who Should Be Screened?

Colon cancer is amenable to screening because it generally develops in a predictable sequence with a long pre-malignant phase. Most colorectal cancer occurs in people with no particular risk factors for this disease so the only effective way to reduce deaths is to screen everyone in the community. Waiting for symptoms to develop is not an acceptable strategy because the symptoms are non-specific and bowel cancer that is symptomatic is often incurable. The question should not be whether people should be screened but when and how this should be done and how participation rates can be maximised.

The main problem with community screening is overcoming people's reluctance to test their faeces. Without encouragement very few people will have this test. The recent pilot study for the national bowel cancer-screening program had a participation rate of 45%, similar to than in other studies overseas[2]. Approximately 1/20 of the original invitees had a positive faecal occult blood result and 1/200 had abnormal colonoscopy findings. At the end of the study there were approximately 70 people with colorectal cancer out of the initial group of 57000 people. These findings indicated that the combination of a direct invitation to participate, a government sponsored program and using a reliable home test kit could detect disease that would otherwise be missed.

When Should People Be Screened?

The risk of bowel cancer rises sharply after 50 years of age so this is the time to start thinking about screening. The Australian program has started by testing people aged 55 and 65 years. At the end of 2006 the testing has been in Queensland, NSW and ACT with plans to start in the other states in the near future (figure 2). Some screening programs in the US invite you to a colonoscopy for your fiftieth birthday.

Screening people less than 50 years of age has a lower yield in the general population and is only indicated in high-risk groups. If screening is left much later, increasing numbers of people with cancer will be missed.

Alan McNeil
Chemical Pathologist

Que Lam
Chemical Pathologist

Matthew Tallack
Scientist

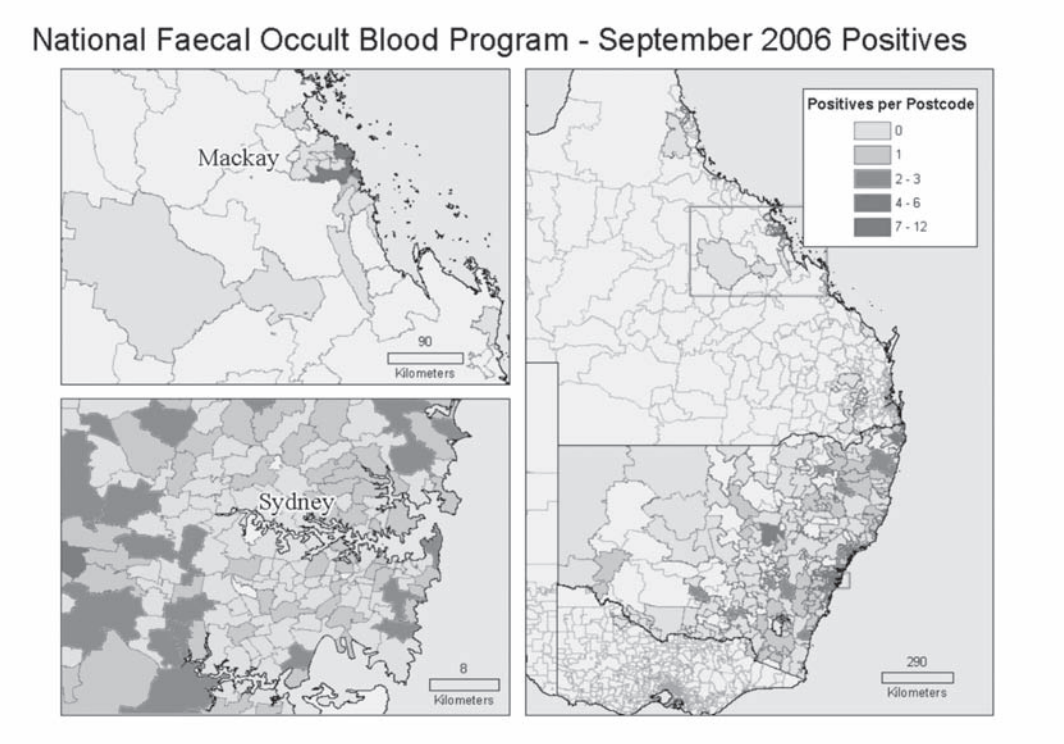

Figure 2. Progress of the National bowel cancer-screening program.

If a person has a negative faecal occult blood test they need to be tested again in one or two years time to detect any cancer that may develop in the mean time. They do not need to be tested again so quickly after a negative colonoscopy however. The reason for this is colonoscopy can detect early, non-bleeding pre-malignant polyps that are missed by faecal occult blood testing.

How Should You Screen Your Patients For Bowel Cancer?

Population screening with faecal occult blood testing has been shown to be cost effective in a number of studies. Colonoscopy and flexible sigmoidoscopy can also be used to screen for cancer but they have not yet been shown to be cost effective. The advantage of these methods is that they can be used to detect and remove early lesions of course. However, the cost and risk are much higher and there is the remote risk that someone could die as a result of the preparation or the procedure. Some health insurers in the USA do pay for screening for bowel cancer by colonoscopy at age 50, presumably having done the calculations showing that the benefits outweigh the costs of this approach in their environment.

CT colonography is a newer non-invasive method for screening for bowel cancer. This has not been evaluated as extensively as faecal occult blood testing, which has been around for several decades. This method may be more sensitive but has the disadvantage of requiring the same bowel preparation as a colonoscopy. The patient will still need a colonoscopy if an abnormality is detected using CT colonography.

Recent research has looked at testing faeces for mutant DNA rather than blood on the basis that tumours may shed abnormal cells even when they don't bleed [3]. The DNA test was more sensitive than the guaiac occult blood test (see below) but more than 50% of cancers seen on colonoscopy were still missed with this method. Further work is needed but this may be a useful test in future.

Practical Issues About Faecal Occult Blood Testing

1. How can I organise faecal occult blood testing for my patients?

There are three options at present. One is to wait for the arrival of the national program. This is screening people aged 55 and 65 years in NSW and Queensland at present but will start in Victoria in 2007.

The second option is to request a faecal occult blood test through your pathology laboratory. Most laboratories will ask the patient to send them one or more faecal specimens

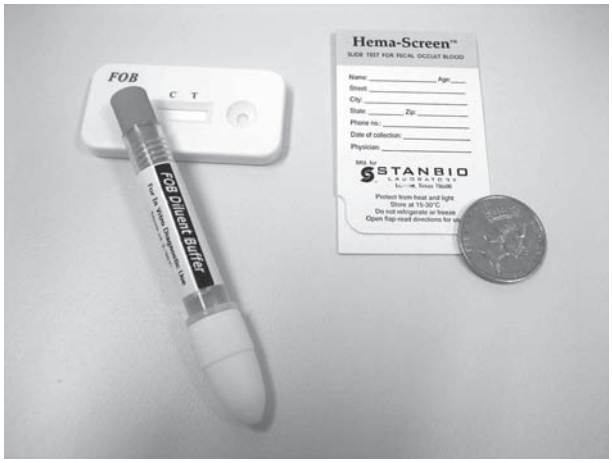

Figure 3. Examples of current manual immunochemical (left) and guaiac (right) faecal occult blood methods. The white and green tube on the left is the holder for the collection probe for the immunochemical method.

and Medicare currently requires the laboratory to use both the older chemical ("guaiac") method as well as the immunochemical method of the type used in the national screening program (figure 3). The advantages of this dual approach are unclear and it is possible it may change as the national program rolls out. People having the guaiac test are supposed to eat a modified diet to reduce the number of false positive results, but this requirement tends to reduce participation.

The third option is for the patient to buy a test kit from the chemist or on the Internet. This way it is possible to have a test that is identical to the national screening program that is reliable, well validated and doesn't require any diet modification. The disadvantage of this approach is that it might cost $50 which will be a disincentive in itself.

2. What is the difference between "Guaiac" and "Immunochemical" testing?

The older guaiac method measures the peroxidase activity of haemoglobin in the faeces – haemoglobin is able to catalyse some of the same reactions as the enzyme peroxidase. This is a well-tested and reliable method but it has significant shortcomings. Some foods like broccoli and horseradish contain large amounts of peroxidase and can cause false positive results while medications like vitamin C can affect the colour reaction and cause false negatives. Various strategies have been used to reduce these interferences but none is completely effective. The newer immunochemical methods use antibodies to detect human haemoglobin and do not suffer the same problems. The best versions of these tests are the ones that can be machine read and give numerical results. This allows for the adjustment of cut-off values and reduces errors caused by operator variation. This is the type of test used in the Australian screening program.

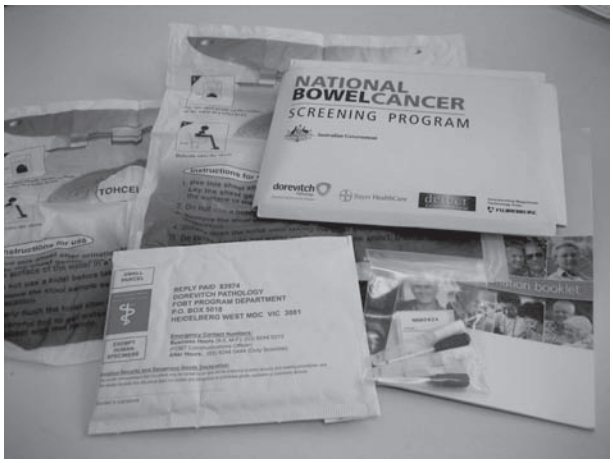

Figure 4. National bowel cancer screening package with information sheet, cellulose sheet for putting in toilet bowel to collect faeces, collection probes and return post-pack.

3. What are the components of the national screening kit?

Figures 4-8 show the components of the test kit being used in the national screening program[4]. Briefly, the patient places a cellulose sheet in the toilet bowl which catches

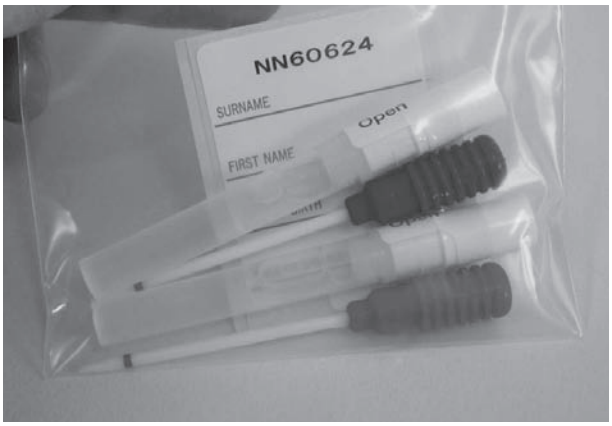

Figure 5. Two collection probes and transport containers.

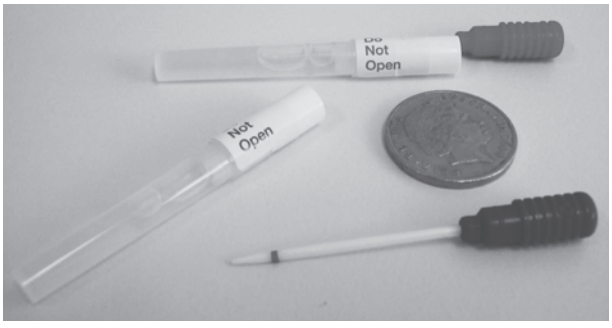

Figure 6. Collection probes and transport containers. The probe is wiped along the surface of a stool specimen so that faeces reaches the red line. It is then placed inside the transport container and sent to the laboratory.

Figure 7. Instrument for automated measurement of haemoglobin concentration in faecal specimens.

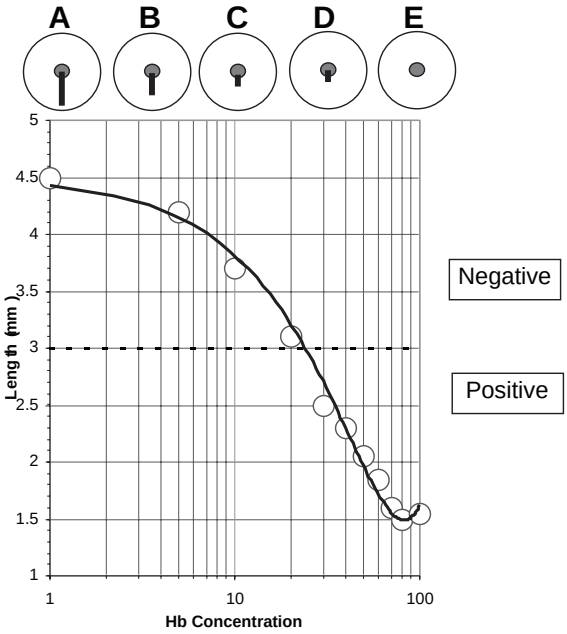

Figure 8. Analyser calibration curve. The circles A-E show the changing chamber pattern inside the analyser as the faecal haemoglobin concentration increases. The graph shows the relation between vertical length of the chamber pattern and Hb concentration with the cut-off at 20 ug/L.

the faecal specimen. They wipe the end of a small plastic probe along the surface of the faeces and place this in a transport container which contains a small volume of liquid preservative. There are two probes (one red and one blue) which are to be used on faecal specimens passed at different times. The probes in their collection tubes are put into a pre-paid post-pack and sent to the central laboratory for testing. If either test is positive the overall result is deemed positive. Both specimens must be negative for the overall result to be negative. The test results are sent to the patient and their local doctor if they have nominated one. If they have a positive result they are advised to discuss this with their doctor and in most cases encouraged to have a colonoscopy.

Conclusions

- Colorectal cancer is a major public health problem in Australia.
- Mass screening using faecal occult blood testing should reduce deaths from this disease by 15-40%, even if the participation rate is less than 100%.
- An Australia-wide bowel cancer screening program has started in 2006 using an immunochemical faecal occult blood test which is easy to use, can be machine-read and requires no dietary adjustment.
- People not included in the program can buy a test kit privately if they wish.
- Medicare funded faecal occult blood testing through pathology laboratories involves combined testing with chemical (guaiac) and immunochemical methods. This may change as the national screening program expands.

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Management of Chronic Obstructive Pulmonary Disease

Christopher Worsnop

Chronic obstructive pulmonary disease (COPD) is defined as airflow limitation that is progressive with an accelerated decline in lung function. It is not fully reversible, in that lung function, as measured by spirometry, cannot be returned to normal. In the Australian community most COPD is caused by smoking tobacco. It places a burden on individual patients as they become short of breath and are limited in what they can do. There is significant mortality, as well as exacerbations that may require hospital admission. These also place a significant burden on the Australian healthcare system.

The disease itself is characterized by inflammation in the airways mediated by neutrophils, macrophages and lymphocytes. This leads to airflow obstruction. There is also inflammation in and destruction of the lung parenchyma producing emphysema. Emphysema leads to impaired gas exchange through loss of the alveolar-capillary membrane, and also leads to airflow obstruction. This is because there is loss of supporting connective tissue around the airways so that they are much more collapsible during expiration. There can also be involvement of pulmonary vessels leading to pulmonary hypertension. The inflammation in the lungs can be seen in the early stages of COPD, and persists even after smoking cessation.

Smoking cessation

Smoking cessation is the most important aspect of the management of COPD. As prevention is better than cure, it is incumbent on all doctors and healthcare professionals to be advocates for antismoking initiatives in our community. It is also essential that we address smoking in all our patients, and in those who are smoking offer advice about quitting. Even a couple of minutes of targeted advice has been shown to improve quit rates. Some patients may be suitable for nicotine replacement therapy and/or bupropion (Zyban), both of which have been shown to double quit rates. In COPD, smoking cessation is the only treatment that has been shown to reduce the accelerated decline in lung function.

Christopher Worsnop
Respiratory and Sleep Physician

Bronchodilators

Bronchodilators have been shown to reduce dyspnoea, improve exercise tolerance and improve quality of life in COPD. Symptoms not only include dyspnoea, but also restrictions in activity by patients in an attempt to avoid feeling breathless. Both these negative and positive symptoms warrant treatment. Bronchodilators can be classified as long-acting or short-acting, and as anticholinergic or β_2 agonist. As COPD patients have persistent symptoms it is preferable to choose long-acting bronchodilators. The number of inhalations per day is only once or twice thus assisting compliance. Nebulisers are generally not recommended as they are more expensive, more cumbersome and less reliable than modern inhaler devices. They also spread respiratory infections.

Tiotropium

Tiotropium is the long-acting anticholinergic. It is used once per day via the Handihaler. Tiotropium has been shown to reduce dyspnoea, improve exercise tolerance, improve quality of life and reduce exacerbations in COPD. The number needed to treat to reduce exacerbations is 14. It has minimal side effects with only a few patients experiencing a dry mouth.

Long-acting β_2 agonists

Of the long-acting $\beta_2$agonists, salmeterol has been extensively studied in COPD. It reduces symptoms and improves quality of life, but there is no advantage in increasing the dose beyond 50 μg per day, as it can then cause tremor and tachycardia. Long-acting β_2 agonists should not be used without an inhaled corticosteroid in asthma. So if there is the possibility of an asthmatic component to the COPD, the β_2 agonist should be used in combination with an inhaled steroid.

Other bronchodilators

Because of their narrow therapeutic window and severe side effect profile, theophyllines are rarely used now. Also, the long-acting anticholinergics and β_2 agonists are more effective. If theophyllines are used, monitoring of blood levels is required. They also interact with other drugs, so care needs to be taken when medications are changed.

Pulmonary rehabilitation

Pulmonary rehabilitation has been shown to reduce symptoms, improve exercise tolerance, and improve quality of life in those who are prepared to complete a programme. An essential part of pulmonary rehabilitation is maintaining regular exercise, particularly after the formal programme has been completed. Thus patients need to be well motivated to get long-lasting benefits.

Vaccination

Influenza vaccination has been shown to reduce severe exacerbations, hospitalisations and death by 50 % compared with placebo, so all COPD patients should be vaccinated each year. Similar studies have not been done with pneumococcal vaccination, but it makes sense for all COPD patients to receive this vaccine as well, and have a second five years later. There is no evidence that regular long term antibiotics are of any benefit, and so should not be used. They predispose people to side effects, and can make colonizing bacteria resistant, making it more difficult to treat acute infections of the airways and lungs.

Supplemental Oxygen

If the PaO_2 is less than 55 mmHg while breathing air at rest and when stable, or less than 60 mmHg with evidence of hypoxic effects such as cor pulmonale, right heart failure, pulmonary hypertension or polycythaemia, then supplemental oxygen for at least 16 hours per day can improve mortality. Patients cannot be smokers, and need to understand that they often do not notice a change in symptoms. Portable oxygen may improve exercise tolerance. It is indicated if the patient desaturates below 88 % with exercise and supplemental oxygen reduces the oxygen desaturation and improves the amount of exercise that can be done.

Corticosteroids

Several large randomized controlled studies have shown that there are some benefits with inhaled corticosteroids in COPD. There are thus two indications for inhaled corticosteroids in COPD. One is that an improvement in spirometry has been demonstrated after a trial of several months. The other is that in severe COPD, that is, $FEV_1 < 50$ % of predicted, with frequent exacerbations, the exacerbation rate can be reduced. One might consider giving a trial of inhaled corticosteroids if there is a suggestion of asthma in the patient's history, if some acute reversibility is seen on spirometry or if other treatments have not produced a satisfactory response and the patients is keen for some further improvement in his/her symptoms and exercise tolerance.

The ISEEC Study (Sin et al 2005) attempted to determine if inhaled corticosteroids in COPD can reduce mortality due to all causes, by pooling the data from seven randomized controlled trials in which over 5,000 patients had been enrolled. This retrospective analysis showed that all-cause mortality was reduced by 27 % with inhaled steroids. The effects were larger in women (54 %) and in those who had given up smoking (40 %).

The benefits seen with long-acting β_2 agonists, and with inhaled corticosteroids has naturally led to studies assessing the benefits of the combination of these two classes of drugs. The TRISTAN study (Calverley et al 2003) compared placebo, fluticasone 500 µg bd, salmeterol 50 µg bd and fluticasone 500 µg / salmeterol 50 µg bd over 12 months in COPD and found that greater increases in FEV_1, quality of life, and a reduction in exacerbation rates, and more days without rescue medication were obtained with the combination.

Qui et al (European Respiratory Society presentation 2005) explored this further by performing bronchial biopsies in COPD patients treated with fluticasone/salmeterol combination or placebo. They found significant reductions in CD8, CD4, CD45mast cells, TNF α and interferon-γ levels, showing that the combination has some anti-inflammatory effects in COPD.

However, there is no evidence to show that the long term use of prednisolone in COPD is of any benefit, and because of the frequent side effects it causes, it is not recommended for chronic use in stable COPD. Short courses of one or two weeks are of benefit in COPD exacerbations. The prednisolone can be stopped without any tapering when used in short courses like this.

Other Treatments

In younger patients who are otherwise well, and who have quite disabling COPD, referral for lung transplantation or lung volume reduction surgery could be considered. Chronic use of non-invasive ventilation at home is not very

well tolerated, and has not been shown to be of great benefit so is generally not used. Mucolytics have some benefit in selected patients, but are not for routine use in COPD.

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General Surgery: Current Issues in Practice, Hospital Management and Academia

Lean-Peng Cheah

The following are a number of topical issues currently affecting the General Surgeon practicing in Melbourne

Screening for colorectal cancer

The following are a number of topical issues currently affecting the General Surgeon practicing in Melbourne Faecal occult blood test screening has commenced in Australia – interestingly the GPs I have spoken to have not been directly involved with this project. There is also inadequate funding for the hospitals to meet the increase demand in colonoscopies. Currently most hospitals are struggling to do the category 2 colonoscopies within the 90 day waiting period. This is on top of the time that the patient has to wait for an outpatient clinic appointment!

gene profiling in cancer - increasing use of molecular Genomics information To Guide Treatment

Herceptin has only been recently approved here by the PBS. Breast cancer is a clinically heterogenous disease. The TNM staging system and the estrogen, progesterone and HER-2 receptor status, and the Nottingham Prognostic Index are the current methods commonly used to determine prognosis. Newer and more accurate tests are being developed. Multigene assays that may help predict response to specific chemotherapy have been trialled. There is now a multigene diagnostic assay commercially available in the States which amongst other things measures ER and HER2 expression and also its functionality (looking at expression of downstream ER-regulated genes.)

Inguinal Hernia repair – Laparoscopic vs Open

Which is better? The proponents of laparoscopic hernia repair say that there is less post-operative pain with laparoscopic repair in their hands. Those who do an open repair usually find that their patients don't have much pain anyway. Furthermore, an open inguinal hernia repair can be done under local anaesthesia with less risk of a DVT. The disposable equipment makes laparoscopic repair much more costly, in addition to its increased risk of complications such as bleeding, scrotal collection, subcutaneous emphysema and increased recurrence rates!(According to data from a large randomised controlled trial from the USA)

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General Surgeon – Public Appointments : Eastern Health, Ballarat and Echuca

Antibiotic prophylaxis for mesh inguinal hernia repair

IV antibiotics (eg cephazolin) are recommended by the latest Antibiotic Guidelines for all hernia repairs with mesh/plug. Interestingly, of the papers referred to, most RCTs did not show any difference between those with or without antibiotic use. One paper from Spain showed a significant advantage to antibiotic use.

Breast cancer – Assessment of nodal status : sentinel lymph node biopsy vs axillary clearance

Increasingly sentinel lymph node biopsy is being used as the primary method for assessing nodal status because of its much lower risk of lymphoedema. In addition a drain is not required. Axillary clearance still has a place in cases of multifocal tumours, confirmed axillary metastases and where the sentinel lymph node biopsy is positive. For the latter indication, there will be more data in the coming year as to which patient groups with sentinel lymph node involvement do not need axillary clearance.

laparoscopic cholecystectomy: management of the CBD Stone found at operative Cholangiogram

For stones found on operative cholangiogram at laparo-

scopic cholecystectomy, there has for some time been a debate on which is better - laparoscopic transcystic CBD exploration vs ERCP. The disadvantages of an ERCP are its risks including bleeding and pancreatitis. More specifically from the sphincterotomy, the risks of duodenal-biliary reflux with associated long term risks of epithelial metaplasia and cholangiocarcinoma. However, stones found in the CBD may not be easily extracted via a small cystic duct during a laparoscopic exploration. In addition, there is a risk of mortality from ERCP(someone once commented that the risks of an ERCP is as high as elective open heart bypass surgery!).

From the practical point of view, ERCP is not often easily available. The patient may have to wait for several days before the next list and in some cases, the patient may have to be transferred to another hospital where ERCP is available.

Informed consent

Generic consent forms vs case-specific consent forms (like the ones produced by the Queensland DOH) - how much does a patient need to be told? And how can we be sure the patient remembers everything? There is really so much to know and so many possible complications for a specific procedure, even for a common one like laparoscopic cholecystectomy. Interns are not allowed to obtain consent for operations from patients – this is on the basis (quite rightly) that they may not be aware of the nuances of the procedure despite assisting/seeing a number of the operations.

What figures to provide to the patients is another issue. For laparoscopic cholecystectomy, the Queensland consent forms specifically states that 1 in 7 patients would have persisting pain post-laparoscopic cholecystectomy.

Bowel preparation for colorectal surgery

Despite common practice and common sense, studies have once again shown that patients who have bowel prep before their colorectal surgery have a higher incidence of anastomotic leaks and wound infections. Reasons for this may include the altered bowel flora once a patient is given bowel prep, dehydrated state from the bowel prep and the more liquid faeces.

Chewing gum helps earlier return of bowel function?

There was an interesting paper from the States last year about chewing gum reducing the time of post-operative ileus following bowel resection!

(On a lighter side, after reading this article, on the first patient I wanted to try it on – the patient told me that he could not take chewing gum because of his dentures!)

Best treatment for pilonidal sinus disease - Tips learnt from Mr Paul Kitchen

For a pilonidal abscess, it is best drained with a small incision away from the midline, rather than excising widely and laying it open to heal, and then reviewed in the outpatient clinic for consideration of definitive surgery.

Definitive surgery should aim to bring the scar away from the midline to reduce the risk of recurrence. The modified Karydakis operation(excision of the sinus tract and cavity with a local flap) is best, with a very low recurrence rate. This can be done under GA or local anaesthesia & sedation.

(The Colorectal Surgical Society/RACS patient information pamphlet states a recurrence rate of between 11-38% for primary direct closure and 5-15% for flap closure – which is much higher than Paul Kitchen's figures using the modified Karydakis technique)

An office procedure that can be done in uncomplicated disease is to excise out the tract alone under local anaesthesia (Bascom procedure).

Public hospital elective waiting list and the hidden waiting list

The elective waiting lists are generally longer in Melbourne hospitals than in regional areas especially for Category 2 & 3 patients. But even within Melbourne, variations exist among various hospitals in waiting times eg. for hernia repair, laparoscopic cholecystectomy, varicose veins.

Additionally, there is another unofficial waiting list to attend the outpatient clinics – this is the delay from when the referral is first made to when the patient finally gets his appointment. (In fact in one hospital, the appointment dates for surgical outpatients can only be given from Oct 2007! In the meantime, all the referrals are filed in a "waiting for outpatient appointment" folder).

The common sense solution is to simply not shut down so many theatre and outpatient sessions. Theatre slow-down/

shut downs are increasingly more common over Chrismas-New Year (4-6 weeks in some hospitals). In addition, some hospitals close theatre and outpatients over the Easter week and even the September school holidays if the hospital is over WIES targets. Unfortunately, the hospital executives have a budget to meet and there is also the situation whereby if the outpatient clinics are left open, then the waiting lists will increase and the hospital will be further penalized if the waiting times are exceeded!

Waiting list initiatives

The waiting list initiatives has helped a bit in the previous years – extra funding for surgeons to do more cases (sometimes in another hospital with a shorter waiting list).

The new Alfred Centre should help too as often the main problem in the quarternary hospitals are that the emergency cases and major/cancer cases take priority over the hernias, laparoscopic cholecsytectomies and varicose veins. Given the waiting list for the Alfred Hospital itself is not that long and it has received extra funding, the Alfred Hospital's CEO has written to CEO's of other hospitals offering to take patients off their waiting lists. (Eg it offered to take 20 endoscopies off a regional hospital's waiting list)(Author note: what I don't understand with this is why doesn't the DHS fund the primary hospital better in the first place – eg if the theatres do not have to be shut for so long in the primary hospital over Christmas and January/Easter/September school holidays, then more cases from the waiting list can be done. In this particular regional hospital's case, it means that the patients have to travel more than 100km to have their endoscopy done if this was accepted. I am not sure as to how many toilet stops the patient would need to have on the way there if they have had bowel prep for their colonoscopy!)

Time out : Correct Side, Correct Patient and Correct Operation

The DHS now requires that all theatres have a policy in place for a team time-out before the operation. Quite rightly so! It is never too wrong to double or triple check!

General surgical services to regional Victoria

The average age of general surgeons in regional Victoria is continuing to increase with many approaching retirement age. It is going to be an increasing problem in the near future. Some towns have a Catch 22 – there is often not enough work to attract a younger surgeon into town. Often the hospitals are telling the General Surgeons already there that they are spending too much WIES and are cutting down on services to avoid going over budget.

New Surgical Training Program

The RACS is planning to change its surgical training program to a seamless 5 year program(SET) with a single entry point as opposed to the current Basic and Advanced Surgical training. This would be a move towards the American model. It is increasingly being recognized that the average age of medical graduates is increasing. Surgical training has to be made shorter but still provide enough operating opportunities.

The main issue with this are the selection criteria – how to best select the surgical candidates fairly at a very early stage. At present the referee reports are hard to standardize and are very variable. Some hospitals give practice interviews to their trainees applying for BST and AST giving them an advantage over others. Also there are good candidates who do not perform as well in interviews.

Medical education (especially anatomy teaching)

The "dumbing down" of the medical syllabus because of time constraints especially with graduate entry students and the need for non-graduates to spend a year doing a Bachelor of Medical Science (of variable quality) has been noted. There have been significant problems in the level of knowledge of recent graduates, especially in Anatomy. (In fact a lot of surgical trainees take time off surgical work to teach anatomy and do a Diploma in Anatomy these days – what they learn through this is equivalent to what was taught in Anatomy in the University of Melbourne in the 1990s as undergraduates).

I have heard that the University of Melbourne recognizes this problem and plans to revamp its curriculum – shifting back towards the middle ground.

(And speaking of anatomy – Norm Eizenberg's book will be out this year!)

Are there going to be enough teachers for all the medical students in Victoria?

With the new medical school at Deakin University and Notre Dame University also sending its students to Victoria, there is going to be a dramatic increase in the number of medical students. Where will there be enough places for the students to see enough surgical cases? Even now, the medical graduates are struggling to get enough exposure to the breadth of cases in general surgery especially with more

Update in the management of chronic hepatitis C —a silent epidemic

Ferry Rusli

Introduction

Hepatitis C virus (HCV) is an RNA virus that was discovered in 1989 . Prior to this, it was described as non-A non-B hepatitis. It is very common and tends to be asymptomatic in most cases (until patients develop advanced/ decompensated liver disease).

Between 1990 to 2000, approximately 160,000 notifications were received by the state/territory jurisdictions; making it the most notified communicable disease in Australia([1]). It is estimated that 1% of the Australian population (ie approx 250,000) has been exposed to hepatitis C virus (HCV antibody positive) and 75% became chronic (ie positive HCV RNA by PCR); 25% of people exposed to HCV cleared it spontaneously (ie lost the HCV RNA by PCR but have remained HCV antibody positive).

HCV infection is the number one indication for liver transplantation in Australia and these are mainly for patients who have developed decompensated liver disease (a smaller percentage for patients who developed hepatocellular carcinoma associated with HCV) ([2]).

Diagnosis

HCV antibody testing should be offered to all of the following patients:

i) Migrants from endemic areas (South-east Asia -- Vietnam, Cambodia, Indonesia; Africa; Eastern Europe; certain parts of Mediterranean countries)—the route of acquisition can be due to vaccination needles, dental procedures & tattooing but the majority do not have an obvious exposure – being born in these countries is a risk in itself.

Ferry Rusli
Gastroenterologist

ii) Patients with abnormal liver function tests (do not assume it's just alcohol or fatty liver)
iii) History of blood transfusion or tattoos
iv) Injecting drug users (85% of patients with chronic HCV acquired it through this route in Australia)
v) History of incarceration
vi) Contacts with HCV positive people
vii) Patients with thrombocytopenia, renal impairment (can present as glomerulonephritis)

Firstly screen with the HCV antibody test. If it comes back positive, then order HCV RNA by PCR as well as genotyping / viral load. Some patients who have just acquired the virus (acute hepatitis with/without jaundice) may not have developed HCV antibody early enough; hence HCV RNA should be performed if there is a high index of suspicion or alternatively repeat the HCV antibody in 4-8 weeks time.

HCV is rarely transmitted during vaginal delivery (<5%) or sexual intercourse (except at times of menstruation or rough sexual practices or anal intercourse).

Unfortunately, there is no vaccine yet for HCV; hence prevention is the key to tackle the rising of this disease. For those who have already developed chronic HCV, treatment is now available that can lead to clearance of the virus in a percentage of people.

Treatment

Treatment is effective (curative) in approximately ***55%*** of people with chonic HCV, ie permanent loss of HCV RNA by PCR ([3]). Treatment should be considered for all patients who have chronic hepatitis C.

Even though only a small percentage of people progress to cirrhosis / hepatocellular carcinoma, the numbers are rising as the younger generation have a higher prevalence of HCV and the longer they have the virus the higher the chance of progressing to cirrhosis.

Factors that lead to faster progression to advanced liver disease/cirrhosis:

a) male
b) excessive alcohol intake
c) older age at infection
d) longer duration of infection
e) coinfected with hepatitisB/D/HIV
f) other liver disease (fatty liver/ haemachromatosis etc)

Factors favourable in responding to treatment:
a) Genotype 2 or 3
b) Low viral load (<2 million copies/ml)
c) Age <40 yrs old
d) Female
e) Low fibrosis score on liver biopsy

The commonest HCV genotype in Australia is 1 followed closely by genotype 3. The response rate to combination therapy for genotype 2 or 3 is as high as 80% (duration of treatment is 24 weeks). The response rate for genotype 1 is less than 50% (duration of treatment is 48 weeks).

Combination of pegylated interferon and ribavirin is the mainstay of treatment for chronic HCV at the moment. Pegylated interferon has a longer half-life than conventional interferon. It is given once a week subcutaneously (self-administered like insulin—after an education session with a nurse consultant) instead of 3 times a week (for conventional interferon); hence it has less side effects than conventional interferon.

The side effects of interferon include:

a) Tiredness/lethargy
b) Flu-like illness
c) Pancytopenia (blood test every 4 weeks needed)
d) Mood changes (depression/exacerbation of psychosis)—needs formal psychiatric assessment for those with past history
e) Loss of appetite & weight loss (4-10kg)
f) Temporary hair loss
g) Exacerbation of autoimmune disease (thyroid, psoriasis)

Ribavirin is given orally (4 to 6 tablets per day depending on body weight). It doesn't work on its own and has to be given in combination with interferon.

Side effects of ribavirin include:
a) Haemolytic anaemia (dose will be reduced accordingly)
b) Teratogenicity
c) Cough/ shortness of breath
d) Dizziness
e) Rash

Contraindications to interferon:
a) Decompensated liver disease
b) Pregnancy
c) Active psychosis/depression
d) Uncontrolled autoimmune disease.
e) Active drug use
f) Excessive alcohol intake (ideally nil during treatment or < 7units per week)
g) Poor compliance/ unstable social situation

Contraindications to ribavirin:
a) Anaemia (eg transfusion-dependent thalasaemia)
b) Renal failure
c) Pregnancy
d) Inability to use 2 forms of contraception
e) Significant cardiac disease.

Patients with persistently normal alanine transaminase (ALT) / liver function test (LFT) are eligible to be treated since 2004. Approximately 25% of patients with persistently normal ALT/LFT have advanced liver disease on liver histology (ie fibrosis 2 or above ----with fibrosis 4 as cirrhosis)([4,5]).

The response rate to treatment in patients with persistently normal ALT is the same as those with abnormal ALT ([6]).

From April 2006, liver biopsy has been removed as a pre-requisite to access treatment . However, liver biopsy is still useful in those patients with a diagnostic dilemma (ie those with a probability of overlapping liver disease such as autoimmune hepatitis) and those with a probability of advanced liver disease (eg cirrhosis). If patients have early cirrhosis on histology (not detected by radiological means or biochemically), they will need regular hepatoma screening and will be encouraged to have early treatment and hopefully better compliance during treatment.

Those who remained HCV-RNA (by PCR) negative at 6 months post-treatment (sustained responders) can be considered cured. When patients have responded, they will feel better symptomatically , psychologically and they will not progress to advanced liver disease (ie cirrhosis or hepatoma).

Those unfortunate patients who do not respond to treatment can still take part in new oral antiviral therapy trials (many public hospitals are involved - Monash, St Vincent's & Alfred).

For those who develop decompensated liver disease, liver transplant is an option but the waiting list is long. After the transplant, the new liver will invariably be reinfected (100%) and some of these patients will develop cirrhosis again with their new liver.

For those with acute hepatitis C (ie documented HCV antibody positivity within 6 months of a previous negative HCV antibody or newly positive HCV-RNA), they should be referred immediately to liver clinics as they can respond to treatment very well (up to 99% response rate) if they failed to clear spontaneously.

SUMMARY POINTS

- Chronic HCV is common (1% Australians have been exposed)
- Treatment is now available and can lead to a cure in 55% of patients
- HCV genotype 2 and 3 have the best response rate (up to 80%)
- Patients with persistently normal ALT/LFT can still have advanced /progressive liver disease
- Patients with normal ALT/LFT are eligible for treatment
- Liver biopsy has been removed as a pre-requisite for combination therapy for HCV (not in hepatitis B though)
- Vaccine is not available; prevention is crucial.

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Guide to Hepatitis Serology

Gillian Wood, Chandrika Perera, Caroline Reed

The Microbiology Department at Dorevitch Laboratory often receives enquires from General Practitioners and Clinicians regarding the interpretation of serology results. To assist in this regard, we have formulated some information which may be of use.

The sections are divided into tests for Hepatitis B, A and C.

Hepatitis B

Serological test	Explanation of Serological test
Hepatitis B **surface** antigen	Presence indicates **current Hepatitis B infection**. **Note:** 1) Does not differentiate between acute and chronic Hepatitis B without further tests or previous tests 2) Usually the earliest detectable serum marker for acute Hepatitis B infection
Hepatitis B **surface** antibodies	Presence indicates **immunity** to Hepatitis B infection **Note:** 1) Does not differentiate between vaccine-induced immunity and immunity after recovery from Hepatitis B infection without further tests (especially Hepatitis B core total antibodies) 2) Absolute levels may wane over time, particularly after immunisation, but does not necessarily mean loss of immunity (See Australian Immunisation Handbook 8th Edition 2003).
Hepatitis B **core** total antibodies	Presence indicates **current or past Hepatitis B infection** **Note:** 1) Does not differentiate between current or past Hepatitis B infection without other tests e.g. HBsAg 2) NOT produced after Hepatitis B immunisation 3) Usually remains positive life-long, but may wane 4) May get isolated positive result: (i) This usually means past infection with waning of Hepatitis B surface antibodies. (ii) Occasionally this may be due to a non-specific (false positive) reaction. (iii) Rarely this may be due to undetectable Hepatitis B surface antigen levels, and positive infectivity. If there is evidence of liver disease, consider HBV DNA testing.
Hepatitis B core **IgM** antibodies	Presence indicates recent acute Hepatitis B infection **Note:** 1) Usually remains detectable for up to 6 months after acute Hepatitis B 2) Occasionally seen in acute exacerbations of chronic Hepatitis B
Hepatitis B e antigen	Presence indicates **highly infective** stage of Hepatitis B **Note:** 1) May be negative in "pre-core mutant" form of Hepatitis B which is still highly infective - further tests, such as **HBV DNA**, may need to be performed to show high level of infectivity
Hepatitis B e antibody	Limited use clinically **Note:** 1) Level may become undetectable over time 2) May be positive in "pre-core mutant" (see above, Hep B e antigen)

Hepatitis A

Serological test	Explanation of Serological test
Hepatitis A **total** antibody	Detects the presence of both IgM & IgG to Hepatitis A Presence indicates either: 1) Previous exposure to Hepatitis A 2) Previous immunisation to Hepatitis A 3) Recent/acute Hepatitis A (in the presence of positive Hepatitis A IgM antibodies)
Hepatitis A **IgM** antibodies	Presence indicates **acute** Hepatitis A **Note:** 1) Occasional false-positives due to cross reactions from other infections 2) May not always be detectable at onset of illness ⇛ may need to repeat HepA IgM 7 days after initial negative result if still highly suspicious for acute Hepatitis A 3) Usually remains detectable for 2-4 months (up to 6 months) after acute infection

Hepatitis C

Serological test	Explanation of Serological test
Hepatitis C antibodies	Presence indicates **current or past Hepatitis C infection** **Note:** 1) Does not differentiate between acute, chronic or resolved infection 2) May not be detectable for up to 3 months after acute exposure (incubation period) ⇛ repeat testing recommended (or HepC PCR) if highly suspicious for Hepatitis C infection despite initial negative HepC Ab result 3) **False-positive reactions are common** and require supplementary tests to resolve 4) Positive reactions require a second Hepatitis C antibody test to confirm the findings of an initial positive test (this is a <u>different</u> test to the initial screening test)
Hepatitis C **RNA** polymerase chain reaction (PCR)	Presence indicates **actively replicating** Hepatitis C virus - the test detects viral RNA **Note:** 1) Levels may vary with time, giving discrepant PCR results over time in the absence of Hepatitis C therapy 2) Absence in a single test does NOT necessarily indicate resolution of infection 3) Repeated testing is mainly used to follow efficacy of anti-Hepatitis C therapy

For further information please contact Dr Caroline Reed, Dr Gillian Wood & Dr Chandrika Perera in the Microbiology Department on (03) 9244 0444.

Recent Changes to the Guidelines for Cervical Cancer Screening

Valerie Surtees

Several modifications were made to the national screening guidelines for cervical cancer screening in July 2006. The following short notes outline these modifications with particular emphasis on the changes to the management of possible or definite low-grade squamous lesions and the introduction of Human Papilloma Virus typing as a "test of cure" for high-grade squamous lesions.

The new guidelines include:

- Minor changes to the report format – you will note that in particular there is no longer a separate statement of specimen adequacy.
- Changes to the recommendations and follow-up for women with an equivocal low grade or low grade squamous intraepithelial lesion. (See separate section below).
- Modifications to the "Category" headings in the report. This is to align the Australian reporting system with the widely used Bethesda system.
- The addition of Human Papilloma Virus (HPV) testing as a Medicare rebatable item for women with a previously treated High Grade Squamous abnormality. (See separate section on HPV testing).

You should be aware that there has been strong debate by the membership of both the Royal Colleges of Obstetrics & Gynaecology and Pathology of Australasia, particularly with the changes to the management of low-grade squamous intraepithelial lesions. One outcome of this debate is the close monitoring of the new guidelines.

It is important to realise that these are only guidelines and you may choose to vary recommendations on an individual case basis. Management of women with any abnormal/unusual signs and symptoms (eg abnormal bleeding) should be based on these clinical findings.

Valerie Surtees
Senior Consultant, Symbion Health Ltd

Management of equivocal or definite low-grade squamous intraepithelial lesion (LSIL).

The following examples cover the various recommendations for women with a Pap smear reported as definite or possible LSIL:

1. ALL AGES of women with index smear reported as definite or possible LGSIL – Repeat smear at 12 months.
2. If the woman is 30yrs or more AND has no history of Negative cytology in the previous 2-3 years, she should be offered immediate colposcopy OR a repeat smear at 6 months.
3. All women with a repeat smear at 12 (or 6) months that is Negative will have a recommendation for a further smear at 12 months. If this subsequent smear is Negative, routine screening at 2 yearly intervals may be re-commenced.

In the event that the repeat smear at 12 (or 6) months is a definite or possible LSIL or definite or possible HSIL, colposcopy is recommended.

(For full information and background see following site www.nhmrc.gov.au/publications/synopses/wh39syn.htm).

There is now a Medicare rebatable item for HPV testing in women who have had a biopsy-proven/treated HSIL (CIN II and above) in the past.

Some examples:

1. A woman with a recently treated HSIL has further cervical cytology and colposcopy at 4-6 months after the treatment. If both these tests are Negative, a further Pap smear + HPV testing is then performed at 6 months – i.e. 12 months AFTER treatment. The latter two tests are then performed annually until the woman has Negative reports for both on two consecutive occasions. She is then screened according to the recommendation for the general population i.e. currently 2 yearly intervals.

2. A woman who is already having annual cytology review as follow-up for a previously treated HSIL some time in the past (previous NH&MRC guidelines, 1994), may be offered HPV testing as in (1). If both the Pap smear and HPV test are Negative on two consecutive occasions, she may return to 2 yearly screening intervals.

Our laboratory currently recommends the HPV-Digene test for typing high-risk viral types. Some "in-house" versions of this test may be cheaper but the "Digene" test is the only method to have currently been validated in international clinical trials.

Note that HPV typing may be useful in other situations, eg women with equivocal or definite LSIL. However, in such situations the test is not rebatable.

HPV Typing

Human Papilloma Virus is a DNA virus with more than 100 types. Some of these types such as 16 and 18 are frequently seen in women with cervical pre-cancer (HSIL) or invasive cancer. These particular types are referred to as "high risk". The Digene test detects 13 high-risk HPV types and the result is reported as detected/not detected (negative) for high risk HPV.

The specimen may be collected either with the Digene cervical sampler kit (this contains a special cervical brush to collect the cervical cells for the test) or using the ThinPrep vial. Dorevitch Pathology will supply either of these kits. Please note that if you use the ThinPrep vial and do NOT require cytology from the vial that you state for "HPV Test only" on the request form.

Summary for Management of Abnormal Pap Smears

1. Possible or definite low-grade squamous Category on Pap smear with NO previous history – Repeat Pap smear in 12 months.
2. Possible or definite low-grade squamous Category on Pap smear in woman 30 years or over and without a previous Negative smear in last 2-3 years – Refer to colposcopy or repeat Pap smear in 6 months.
3. Next repeat Pap smear in either (1) or (2) is Negative – Repeat Pap smear in 12 months.
4. Next repeat Pap smear after (3) is Negative – Return to normal screening interval i.e. 2 years.
5. If repeat Pap smear after (1) or (2) is possible or definite low-grade squamous Category – Refer for colposcopy.
6. All possible or definite high-grade lesions – Refer to gynaecologist for colposcopy and follow-up. *

(*Occasional difficult cases with eg atrophic change may benefit from a short course of topical oestrogen followed by a repeat Pap smear.)

Australian Government

IMMUNISE AUSTRALIA PROGRAM

A joint Australian, State and Territory Government initiative

National Human Papillomavirus (HPV) Vaccination Program

Summary for General Practice

Eligibility

From July 2007 until 30 June 2009, free HPV vaccine will be available through general practice and other immunisation providers for:

- females aged 12-18 years who missed doses during the school-based program; and
- females aged 18 to 26 years, however, the full course of 3 doses must be completed before the end of June 2009 and before the woman reaches age 27 years.

Free HPV vaccine will also be provided to girls at school aged between 12-18 through school-based programs, starting April 2007.

HPV vaccine has not been approved by the Therapeutic Goods Administration (TGA) for use in females younger than 9 years and older than 26 years

HPV vaccine is not funded for males under the National HPV Vaccination Program

Dosage

GARDASIL® is administered intramuscularly, usually in the upper arm, as a series of three injections over a period of six months. The optimal schedule is:

- first dose - at elected date;
- second dose - 2 months after the first dose; and
- third dose - 6 months after the first dose.

If a shorter vaccination schedule is necessary, the second dose should be administered at least one month after the first dose and the third dose should be administered at least three months after the second dose.

Contra-indications and precautions

GARDASIL® should not be given to any person who has a history of severe immediate hypersensitivity to yeast or any of the vaccine components (aluminium phosphate, sodium chloride, L-histidine, polysorbate and sodium borate), or who has had a severe allergic reaction to a previous dose of the vaccine.

GARDASIL® is not recommended for use in pregnant women. However, there is no evidence to suggest that administration of the vaccine adversely affects fertility, pregnancy or infant outcomes. If the vaccine is inadvertently administered during pregnancy, advice should be given to defer completion of the course until after the birth; there is no need to consider termination.

GARDASIL® can be administered to lactating women.

Administering GARDASIL® should be delayed in a person who has a moderate to severe febrile illness until they have fully recovered from the illness.

Cervical Cancer Screening

GARDASIL® does not protect against all causes of cervical cancer. Remind patients of the importance of ongoing cervical screening. Presentation for HPV vaccination is an ideal time to offer opportunistic cervical screening to sexually active women who are not up to date with their Pap smears.

National HPV register

A National HPV Vaccination Program Register [HPV Register] is being developed by the Australian Government to collect data about the Program. Personal details identifying your patient will be kept confidential.

Personal information collected will be used to evaluate the impact of the HPV Vaccination Program on cervical cancer rates, to issue reminders if the course is incomplete, to issue confirmation the course is complete and to contact vaccine recipients if booster doses are required. If your patient's details are not included in the Register it will not be possible to contact her about booster doses.

Information will not be sought about your patient's sexual history.

Your patients can decline having their details included in the HPV Register.

Data collection is a requirement for girls aged 12-18 years who may have received doses in the school-based program. Data collection is not a requirement for vaccinating females aged 18-26 years, however, the Register will accept data for females in this age group, if they elect to have their details included in the HPV Register.

For more information go to **www.australia.gov.au/cervicalcancer**
or
contact the Immunise **Australia National Infoline: 1800671811**

The management of upper gastrointestinal symptoms: is endoscopy indicated?

Anne E Duggan

Most patients with upper gastrointestinal symptoms can be effectively managed without investigation. Recent long-term follow-up of patients with upper gastrointestinal symptoms shows that most have a benign course.[1,2] A recent follow-up of 300 patients 9 years after investigations showed that 40% were asymptomatic; 70% of these without medication. Such a good outcome is the result of the decline of Helicobacter pylori[3] (making peptic ulcer uncommon and gastric cancer rare in the absence of genetic or ethnic predisposition) and the easy availability of effective acid-suppression therapy (making gastro-oesophageal reflux disease easily treatable). For the vast majority of patients, upper gastrointestinal symptoms are now a dis-ease, not a disease.

These changes in epidemiology and treatment simplify the management approach to upper gastrointestinal symptoms (Box). Gastroscopy now has a low diagnostic yield. A review of 22 studies investigating dyspepsia found that, overall, findings in 50% of gastroscopies were normal, 12% revealed reflux oesophagitis, 33% gastroduodenal ulceration, and 1.2% malignancy.[5] International management guidelines recommend two alternatives to gastroscopy:

- empiric acid-suppression therapy; or
- *H. pylori* testing and treatment.[4]

Acid-suppression therapy is effective treatment for gastrooesophageal reflux disease (GORD), and the "omeprazole test" (a simple trial of omeprazole [40mg twice daily for a week]) diagnoses GORD more accurately than endoscopy, and with a sensitivity of around 80%.[6] For population groups with a high prevalence of *H. pylori* infection, such as the elderly and some ethnic groups, *H. pylori* testing and treatment has advantages. For younger patients, *H. pylori* infection is unlikely, as childhood domestic hygiene has improved.

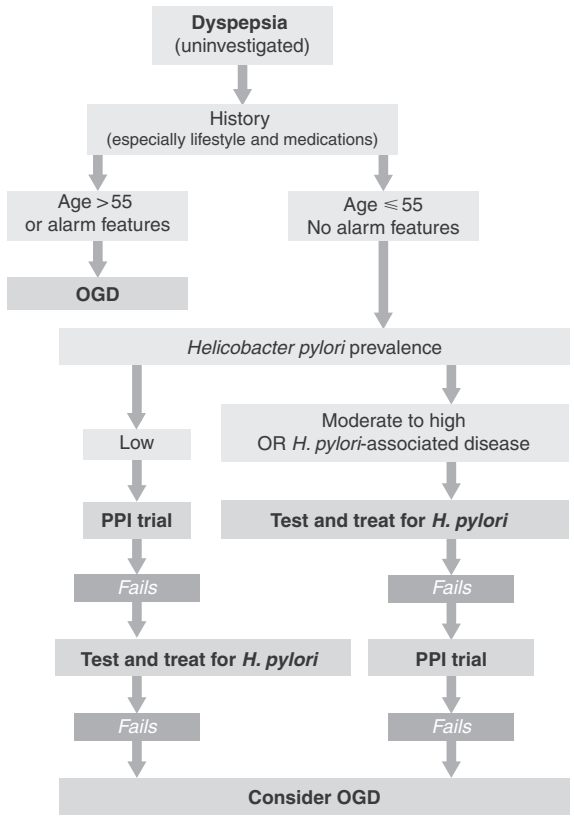
If a test for *H. pylori* is positive, treatment provides:

- definitive treatment of peptic ulcer disease;
- no adverse outcome for non-ulcer disease;
- risk reduction for ulcer disease associated with non-steroidal anti-inflammatory drug (NSAID) treatment; and
- possible risk reduction for future *H. pylori*-associated gastric cancer.

For those who test negative for *H. pylori*, the test provides reassurance.

Population studies have shown that people who do and those who don't consult general practitioners for their

Algorithm for the management of uninvestigated dyspepsia*



* Adapted from Talley.[4]

OGD = Oesophago-gastro-duodenoscopy. PPI = Proton-pump inhibitor. ◆

upper gastrointestinal symptoms have similar symptom severity, suggesting that reasons for consultation may include anxiety about the significance of symptoms.[7] Patients should be asked why they present. For those who want information, data show that lifestyle contributes to GORD and adenocarcinoma development, in particular, obesity, smoking, poor fruit and vegetable intake and a sedentary lifestyle.[8,9] This information is a useful tool in encouraging patients with GORD to modify their risk and improve their overall health. Overly rapid prescription of acid-suppression therapy may waste opportunities for lifestyle modification.

H. pylori testing should be offered to those likely to be infected because of advanced age, ethnic background, or a past or family history of ulcer disease, and to those who take NSAIDs. After advice, and serological or urea breath testing and treatment of patients with a positive result, symptomatic patients can be offered empiric therapy. Whether this should be a step-up approach with initial antacids followed by H_2-receptor antagonists, or a step-down approach with proton-pump inhibitors followed by H_2-receptor antagonists remains controversial, as does on-demand versus ongoing treatment. Population data show that, after initial consultation, a substantial proportion of patients cease therapy or continue on an intermittent basis.[2] There are no data to indicate that for most patients this is harmful.

Non-responders often have non-ulcer or functional dyspepsia and treatment is unrewarding. Prescribed and complementary medications, a frequent cause, should be reviewed. Delayed gastric emptying affects up to 40% of non-ulcer dyspepsia patients and is particularly frequent in patients with long-standing diabetes. Previous gastroenteritis is a recently identified cause of non-ulcer dyspepsia. Prokinetic therapy (with drugs that increase the contractility of the smooth muscle of the upper gut, such as motilium) may benefit both groups.

Endoscopy should be reserved for those with a familial or ethnic risk of upper gastrointestinal cancer, older patients with alarm symptoms such as dysphagia, haematemesis or weight loss[10] and cancer-phobic patients, as its role in patient reassurance is small and not cost-effective compared with other strategies.[11] Concern about missing a cancer diagnosis should be tempered by awareness of its low incidence and the limited value of "alarm symptoms".[5,10]

In 2001, there were 10 gastric cancers and fewer than six oesophageal cancers per 100 000 population reported in Australia. [12] A recent meta-analysis found alarm symptoms had sensitivity of 0–83% and specificity of 40%–98%, and a study of patients with newly diagnosed gastric cancer found poor correlation between symptoms and resectability with:

- 41% having symptoms;
- 81% of these having alarm symptoms;
- 12% of patients with early gastric cancer having prior symptoms;
  and
- no correlation between symptom duration and disease stage.[10,13]

In clinical practice, a third of people with upper gastrointestinal symptoms consult their GP within 6 months of symptom onset.[2,6] As oesophageal adenocarcinoma is associated with severe, longstanding upper-gastrointestinal symptoms, "one-off" endoscopy is unlikely to improve early diagnosis.[10,13]

Today, most patients, particularly those aged under 55 years, can be reassured that:

- their symptoms are benign;
- organic disease, if present, is likely to be responsive to *H. pylori* eradication or acid-suppression therapy;
  and
- their lifetime risk of upper gastrointestinal cancer is exceedingly small and may best be reduced by primary prevention with lifestyle modification.

If the temptation to refer a patient for endoscopy persists, then the question is, is this to meet an unmet need or is an un-need being met?

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Duggan AE. The management of upper gastrointestinal symptoms: is endoscopy indicated. MJA 2007; 186 : 166 -167.

Working with Chinese-speaking Patients

Eng-Seong Tan

There used to be a time in Australia when the predominant Chinese language (erroneously called a "dialect") was Cantonese. This was the language spoken in the Chinatowns of the Australian capital cities; this was the language spoken in the Chinese restaurants and the Chinese groceries. This is a throw-back to the gold-rush days in Australia when the predominant group of Chinese who came as gold-miners were from the province for Guangdong, the southern counties of Guangdong, to be more precise. Indeed there was also another group, a smaller group, from the province of Fujian. These moved to Darwin after the gold ran out and most of them later moved to Indonesia and Malaya or went back to Fujian.

This is no longer the case. In the last two decades or so, there are more and more Chinese migrants from other parts of China and indeed from other parts of South-East Asia for that matter, although the migrants from mainland China still constitute the largest group of Chinese coming to this country. These people speak their native languages among themselves, but when speaking to other Chinese, or even speaking among themselves, they speak Standard Chinese (known to English-speaking people as Mandarin, or putong hua, 普通話). This is especially so among the younger people.

Recently there is debate in Australia about the requirement for migrants to know English before coming here. Although some of these Chinese migrants learn English, a large number of them either do not take the trouble to, or have not succeeded in doing so. As a result they are unable to hold a reasonable conversation in English, read signs in English, and have difficulty understands rules of the various governmental agencies. Worst of all, they are often unable to communicate with these agencies without an interpreter. Although interpreters are generally available in official transactions, they are mostly available only for official transactions; they are most likely not available in situations like purchasing a train-ticket, or a casual encounter with the police on the street. I would prefer to call them translators, because that is all I would want them to do, to translate, and leave me to interpret what the Chinese person is saying to me.

Eng-Seong Tan
Psychiatrist

In the medical context, although there are a number of general practitioners who speak fluent Standard Chinese, not many medical specialists can do this. In the area of psychiatry, I claim to be one of a very few, if not the only one, who can speak enough Standard Chinese to be able to take a complete psychiatric history including a description of the patient's feelings and to do psychotherapy. This means that most of the Standard Chinese speaking patients who need the services of a psychiatrist come to me.

Their failure to understand English and the consequent inability to understand the health care delivery system in Australia give rise to a number of situations which, though not exclusively Chinese, are recurrent and which a medical practitioner has to cope with. I feel these situations should be recorded before these patients and their children become assimilated to the extent that such behaviour is no longer observed.

Keeping appointments

Most of these patients are generally punctual for their appointments. Indeed, if anything they generally come early for their appointments. However. they expect to be seen on time and get very upset if they are made to wait for any length of time. The sentiment seems to be: if I do you the courtesy of coming on time for my appointment, you should return the courtesy of not making me wait. They have difficulty in comprehending that the time a doctor spends with the preceding patients cannot be strictly controlled.

Prescriptions

After a Chinese patient sees a doctor, he or she expects to be given a prescription 處方/藥方. This is what happens in China, and most of Asia. This expectation is there even if the patient was seen one week earlier and was given a four-week supply of medication. This situation is observed even when the patient has a major condition which requires a high dosage of a given medication. He is given a Pharmaceutical Benefits Scheme authority prescription for a larger quantity of the medication to last four weeks with five (or whatever the appropriate number) of repeats. When the patient is seen again later he or she will still ask for another prescription even though they had been told previously that the original is good for six months. It would appear that a prescription lasting for such a long time in not within the conceptual grasp of the patients from China even when they had socialised health care at one time.

Writing certificates

After a Chinese patient has seen a doctor, he would ask the doctor for a certificate 証明书 attesting to what is wrong with him. This is especially required if the patient's condition is related to a work situation, such as a work injury, a compensation claim, etc. The patient generally would show this to the next doctor he sees, which is acceptable, but they would pass this on to the compensation agencies as well. They have difficulty conceptualising the fact that a general certificate would not mean much and is thus a waste of time writing. Worse it could be misconstrued and be used to their detriment. They understand that a report will go to their referring doctor, but what they want is a piece of paper which they can show to others (like a badge of honour) that they had been genuinely injured at work (a testimony to their sincerity and suffering).

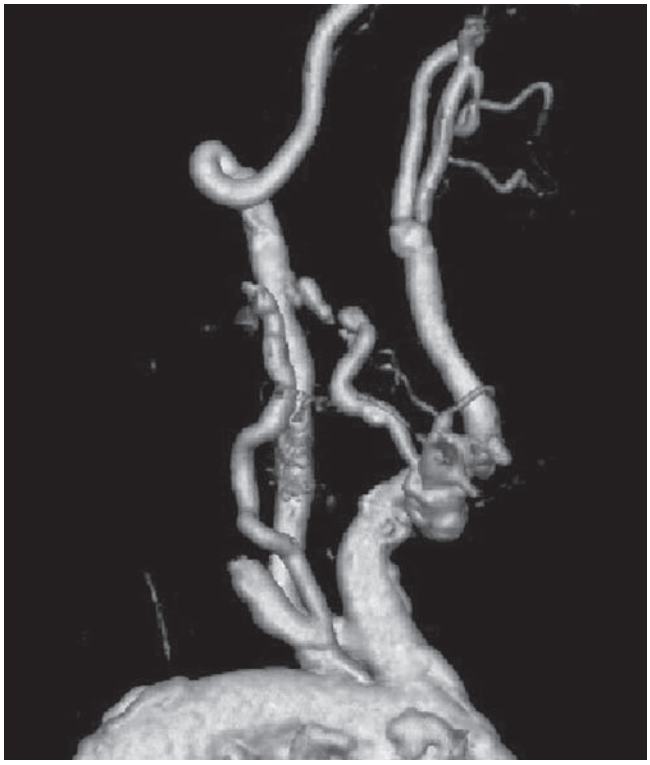
Using social service

The average Chinese worker in Australia who meets with an accident at work knows he will be compensated, but he is unclear how the system works. He has a vague idea that the government will pay him for his injuries. He has difficulty understanding that it is an insurance company and not the government directly which is responsible for this payment. Worse, he is unclear what his rights and obligations are. Some patients have the idea that the government will support them for the rest of their lives.

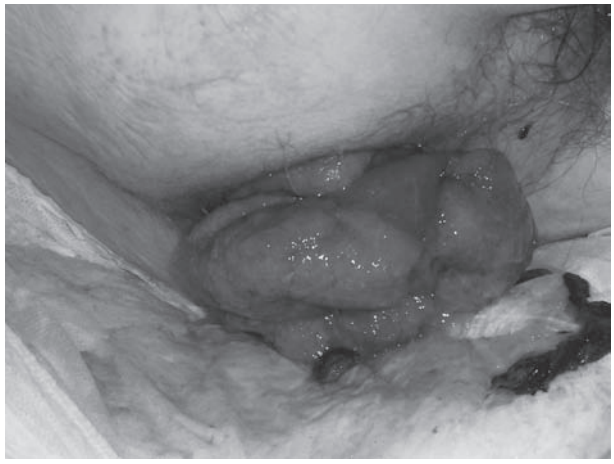
The average Chinese patient in Australia appreciates that when he is not working and has no other source of income, the government will grant him an allowance to live on. What they have difficulty coming to grips with is that fact that there are other social service which are available to help them make life easier, services such as home help. They have difficulty grasping the idea that the local government will pay for someone to come to clean their homes and wash their clothes for them. Meals-on-Wheels is a concept quite foreign and beyond the reach to the average Chinese patient. They find the Australian meal of one meat and vegetables, and a desert, quite unacceptable. They would prefer to buy a take-away meal from a local Chinese restaurant, even if it is not very palatable. At least it has rice or noodles and it is a dish which is Chinese!!

Lessons to be learnt

Lean-Peng Cheah

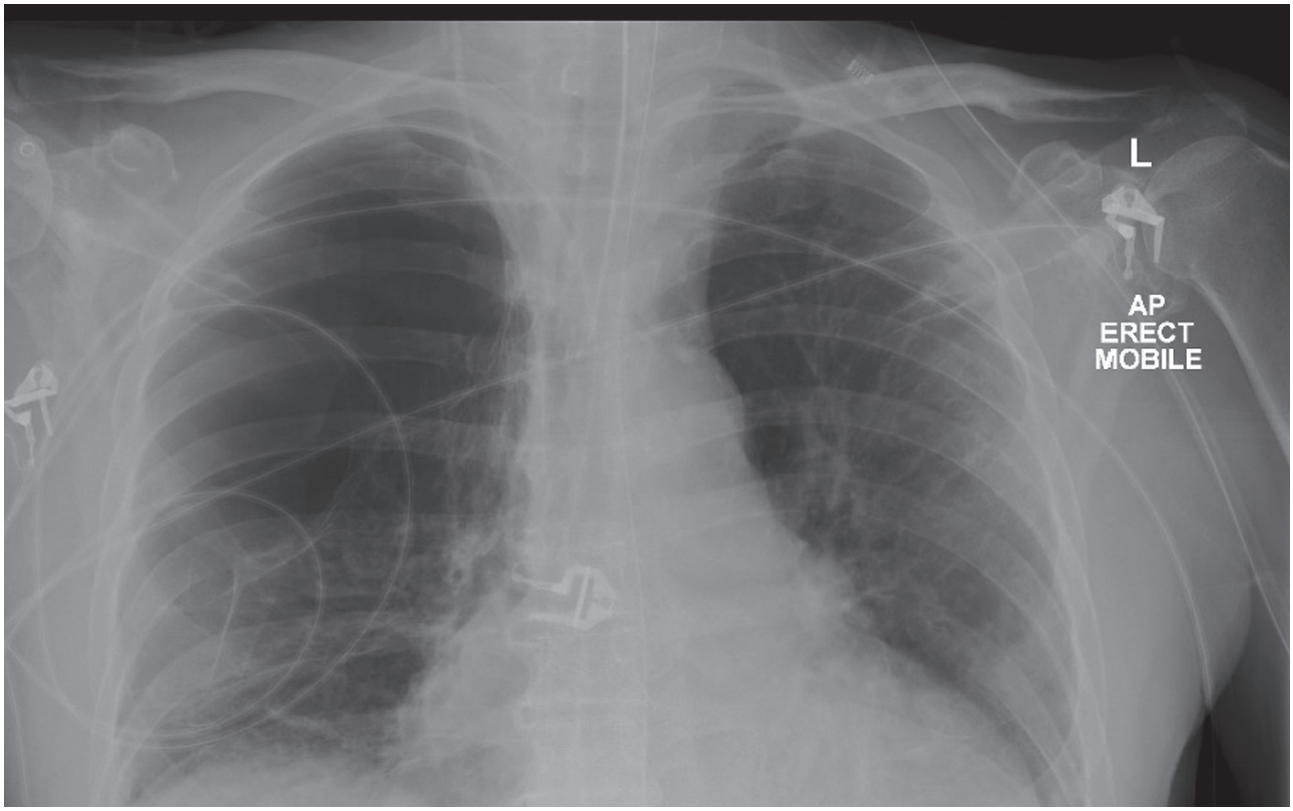


1. Limitations of a radiological investigation. In this case an Internal carotid artery - looping around 360 degrees led to an inaccurate Doppler US report regarding the patency of the ICA and ECA(As can be understandable given the anatomy, it would have been very hard for the sonographer following up the carotids)



2. Importance of a perineal inspection/rectal examination. A patient presented wtih weakness, poor oral intake. Blood tests showed that he had hypokalaemia and renal impairment. An examination of his perineum revealed this huge prolapsing villous adenoma

3. Importance of handovers/better comminucation. In the middle of the night, the ICU resident contacted the oncall (and very tired) Surgical Registrar regarding a postop ICU patient who had reduced oxygen saturation. A CXR had been done and they thought he had a pneumothorax based on the computerized images. (The preexisting bulla in the lung was mistaken for a pneumothorax - a chest tube inserted at night in ICU!) Lesson - 1. Better communication/handovers - the day team and consultants were aware of this. 2. Need to always compare with old films



Food and Health

Siew-Khin (Happy) Tang

In 1985 Gary Butt and Frena Bloomfield co-authored a book "Harmony Rules", in which they descibed how Chinese medicine men or healers (sing seh) associated illnesses in various organ systems to certain foods.

To the Chinese, yin and yang is based on balance of harmony. They are not opposites but rather are dependant on each other to give a harmonious whole.

In their publication, various foods had certain effects on the body's systems. Based on this, the Chinese sing seh was able to prescribe combinations of foods in measured portions or volumes, to alleviate symptoms.

I remember my paternal grandmother (poh poh), who had bound feet and who tottered on exquisitely embroidered tiny shoes, brewing crushed apricot kernel (hung ngan) in boiling water before reducing to half the volume. To this was added honey, and the mixture was then consumed twice daily for five days.

For diarrhoea she would boil rice in water, making a broth, which was taken three times a day. She reckoned this would "flush out the poison from the gut"!

And for 'bloating', raw ginger and brown sugar in boiling water would "get rid of the wind"!

According to Butt and Bloomfield's research, foods had either 'stimulating' or 'calming' effects on the organs in the body.

Examples quoted include :

STIMULATING FOODS	EARTH		METAL		WATER		WOOD		FIRE	
	Spleen	Stomach	Lung	L. Intestine	Kidney	Bladder	Liver	Gall Bladder	Heart	S. Intestine
Apricot		●					●		●	
Beef	●	●								
Corp	●		●		●		●			
Celery		●	●		●					
Chicken	●	●					●			
Chilli		●		●			●			
Coriander	●	●							●	
Garlic	●				●					
Ginger	●	●	●							
Onion	●		●	●			●			
Pepper		●	●	●						
Shrimp			●				●			
Vineger, Wine							●			

Siew- Khin (Happy) Tang

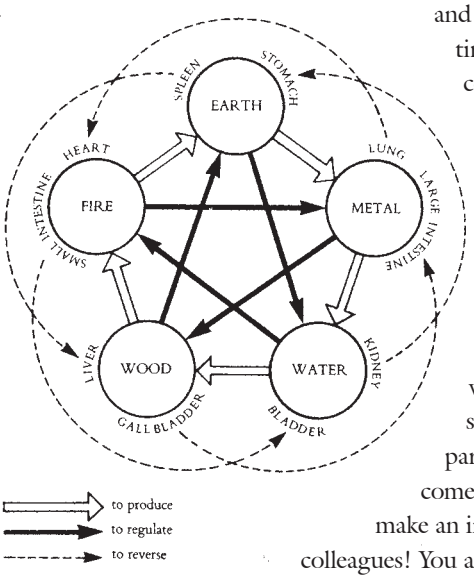
CALMING / COOLING FOOD	EARTH		METAL		WATER		WOOD		FIRE	
	Spleen	Stomach	Lung	L. Intestine	Kidney	Bladder	Liver	Gall Bladder	Heart	S. Intestine
Abalone			●				●			
Banana			●	●						
Soyabean/tofu			●	●						
Cucumber		●								●
Duck			●		●					
Egg plant		●		●						
Frog's legs	●	●								
Kelp		●					●			
Lettuce		●		●						
Mango	●	●					●			
Marrow	●		●	●						
Chinese Mushroom		●					●			
Orange/citrus		●		●						●
Oyster					●		●			
Pear		●	●						●	
Pumpkin		●		●						
Snail	●			●	●					
Spinach		●		●		●				
Sugar cane	●	●	●							
Sunflower seeds			●		●		●			
Green tea	●			●	●				●	
Tomato	●	●					●			
Water crest			●							
Water melon	●		●		●				●	

Many recipes are also detailed by the authors using a combination of foods.

A recipe for "nervous tension" would combine oysters, celery and peanut in a soup which should be consumed twice daily for seven to fourteen days.

For "night blindness" it is recommended that one cup of fresh carrotjuice be drunk daily for 10 to 20 days (yellow discoloration of the skin is not mentioned!).

There is also caution for certain foods: for example vineger should not be taken by "people suffering from muscle cramps or stomach ulcers and cavities in their teeth",



and green tea "should not be drunk when tired or fatigued, nor should it be combined with taking ginseng or other medication".

A summary of the physiological interactions is illustrated in the diagram of "Five ElementsChain of Reactions".

Some of us who are more senior would be able to recall the myths and superstitions observed by our grandparents or great grandparents. How we come to terms with these beliefs would make an interesting study for our more academic colleagues! You are welcome to share any of your childhood memories in our publication.

(Information from " Harmony Rules", by Gary Butt and Frena Bloomfield. published 1985: Arrow Books Ltd.)

The Absence of Many Voices in Protest

Australian medicine faces a life-threatening disease in the form of an unprecedented grab for control by governments. Its latest symptom is the potential hijacking of the profession's control over self-regulation and education. These are slated to become the responsibilities of committees in which doctors will have less influence. The extent of the hijack will become clearer when the Council of Australian Governments establishes a national body to register and set competency standards for doctors and other health professionals, and a national accreditation body to establish standards for their education. With these developments, what will be the fate of medical boards, medical colleges and the Australian Medical Council?

This grab for control is a worldwide phenomenon, as "the regulation of the medical profession is subjected to unprecedented, and growing, public debate, increasing intervention in the daily professional activities of physicians, and increasing oversight by the central state".* A recent World Medical Association press release warned that the WMAs Secretary General believed that "...by steady steps, governments were taking away degrees of freedom from the profession's self governing bodies. 'And this is not a cosmetic change - it means democratic participation is being dismantled. We've seen it across Europe, we've seen it in New Zealand, in Hong Kong and elsewhere,' he said. `This is something that is going on very silently, with small steps in many countries"'. And he may well have added we are seeing it in Australia.

But where are the many voices in protest? There seems to be little in the way of overwhelming public response to Australian medicine's life-threatening disease. Could it be that doctors support the reforms, or have become fatigued by their never ending tussles with governments to maintain self-governance? The absence of many voices in public protest may well seal the fate of the profession's independence.

Martin B Van Der Weyden
(MJA, Volume 186 Number 3, 5 February 2007)

* Moran M. The British regulatory state: high modernism and hyper-innovation. Oxford: Oxford University Press, 2003.

Rubbing Out Doctors

Some hospitals in Europe and the United States have prominent displays of the names and photographs of their senior medical staff in their foyers. These doctors' profiles are also to be found on the hospital website. Not only are senior medical staff respected and valued as critical to the hospital's reputation, but it is also recognised that most patients and their families prefer to know something about the doctors providing their care.

Not so long ago, listing senior medical staff in hospital foyers was the rule. Now, walk into most of our leading hospitals and you will have difficulty finding any information about medical staff, and hospital websites are little better in terms of providing this information. This situation is difficult to understand when health administrators and hospital boards continually tell us that their staff are their most valued asset.

So why this rubbing out of doctors? Could it be that the special relationships between patients and their doctors, and their correspondingly high ranking within the community for integrity and trust, give doctors an enviable role in health advocacy? This position in the community may well threaten health bureaucrats and their political masters in developing and implementing policy. One way to reduce this standing is to limit recognition of senior medical staff in hospitals. Some will argue that with team care, this is a good thing, and that doctors should be equal among equals. But who is responsible for the overall quality and development of clinical services; who takes ultimate responsibility when things go wrong? Any failure to recognise this role diminishes the perception of leadership by doctors.

The practice of rubbing out senior hospital staff is part of a "process of progressive emasculation of medical staff in hospital services"." The peculiar thing is that it has been allowed to happen at all.

Martin B Van Der Weyden
(MJA, Volume 186 Number 4,19 February 2007)

* This column is based on: Mahaffey P. Senior doctors must stay part of the picture. *BMJ 2006; 333: 103.*

From Editor's Desk

The Heart of the Matter

When should you call the heart clinic? When you are over 40? When you are overweight? When you are a smoker? When your blood pressure and cholesterol are too high? When your chest is tight? When your breathing is short? When your heart beats irregularly?

While your heart beats ... before you have a heart attack, not after.

This advertisement, played incessantly on commercial radio, targets the "worried well" and invites them to make contact with a heart check clinic for potential cardiac and vascular testing. Given the commercialisation of medicine, self-referral clinics are to be expected. Medicare provides a reliable revenue stream, and aggressive advertising is the key to throughput and success.

Indeed, the business of heart clinics must be booming. In the past 2 years, Medicare statistics reveal an unprecedented doubling in claims for vascular testing. In turn, the federal Minister for Health is considering instituting a ban on radio advertising for heart testing, noting: "I am far from convinced that [they are] a good thing, on public policy grounds."

Herein lies the rub. Direct advertising to the public by pharmaceutical firms and doctors is either illegal or unprofessional. In contrast, advertising by commercial concerns is relatively laissez faire, as ads for erectile dysfunction, prostate problems, and attention deficit hyperactivity disorder choke the airwaves.

But more fundamental issues are at stake. Firstly, self-referral clinics usurp the traditional "gatekeeper" role of general practitioners. Secondly, the Medicare Benefits Schedule (MBS) provisions for health screening are readily exploitable.

The solutions are simple. The analysis of Medicare payments needs to be more rapid and focused. More importantly, the MBS provisions for health screening need to be reviewed urgently by informed professionals.

It's time to get to the heart of the matter.

Martin B Van Der Weyden
MJA, Volume 186, Number 6, 19 March 2007

Medical Student Selection - We Have to Find Another Way

Some may suggest it is time to ask some hard questions of our medical school selection policies. Is the requirement for equality, diversity and political correctness getting in the way of selecting the best and most motivated? .*

Few issues arouse more passionate debate than the admission policies of our medical schools and their ever-changing educational philosophies and course content.

When it comes to student selection, most schools rely upon combinations of academic scores and cognitive aptitude assessment, followed by the elaborate and expensive lottery the interview. But whether these prove to be reliable barometers, predictive of good doctors or good practice, remains dubious.

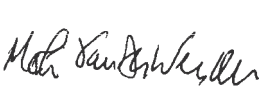
The pragmatic Dutch have long recognised the nebulous nature of these exercises and instead use a state-run lottery for student selection: the higher your academic achievement, the more lottery tickets you receive! Yet in this era of best evidence, Australian medical schools continue with their evidence-poor selection rituals.

Is it not time to move to a uniform, Australia-wide system to allow for, at the very least, prospective and national data and best evidence?

But there is another concern.

Geoff Norman, a prominent Canadian medical educationalist, argues that our current medical school selection processes are "evil", claiming that in "selecting the 10% who are worthy of admission (and hence guaranteed an esteemed and well paid place in society), we are telling the other 90% that they are unworthy ... Yet the evidence we have [for selection] is likely little better than a horoscope."

Instead of continuing with this "professional crap shoot", we have to find another way.



Martin B Van Der Weyden
MJA, Volume 186, Number 7, 2 April 2007

* Ribeiro B (President, the Royal College of Surgeons of England). Thoughts of the New Year. Ann R Coll Surg Engl (Suppl) 2006; 88: 42-43.

From Editor's Desk

Challenges and change in medical training: the Australian Curriculum Framework for Junior Doctors

Martin B Van Der Weyden

A giant step forward, but more needs to be done

To have lived through a revolution, to have seen a new birth of science, a new dispensation of health, reorganized medical schools, remodeled hospitals, a new outlook for humanity, is not given to every generation. [1]

An enduring feature of modern medicine is the constancy of A challenges and change - and no more so than in medical education and training. In the 1980s and 90s, the Australian medical workforce was deemed to be adequate for the requirements of health services and the community and for more than 20 years there was no political pressure to expand the capacity of our medical schools. 3,4 More recently, Australia, along with the rest of the world, has found itself in the grip of a serious medical workforce shortage. This has moved the Australian Government to establish six new medical schools since 2004, in addition to the 11 existing schools. A further five are in the pipeline. [5] With this unprecedented expansion, the number of medical graduates is set to rise from around 1600 in 2005 to about 3000 in 2012.[5,6] In short, in less than a decade, the number of medical schools in Australia - and their graduate output - will have doubled.

Despite the claim that with medical school plurality comes diversity,[7] the purpose of our medical schools is decidedly uniform: to produce a graduate who has the attributes and commitment for lifelong learning and a solid foundation on which to build a clinical and professional career. The Australian Medical Council details this foundation in medical knowledge and understanding, skills, and professional behaviour, and notes: "The goal of medical education is to develop junior doctors who possess attributes that will ensure that they are initially competent to practise safely and effectively as interns in Australia or New Zealand, and that they have an appropriate foundation for lifelong learning and for further training in any branch of medicine."[8]

Medical education is a continuum from medical school to independent practice, but the prevocational years (PGY1 and PGY2) interposed between undergraduate and vocational training are crucial in the quest for good medical practice and good doctors. And herein lies the rub - the prevocational years have been labelled as a lost opportunity for medical education.[9] The factors responsible for this are many and include the apprenticeship nature of training; 10-12 an ill-defined curriculum; 10 training by time-poor and variably competent teachers;[10] variable teacher training; 13 the clash between the priorities of service delivery and education; 10,12 and variable resourcing of teachers, program supervisors, and the state or territory postgraduate medical education councils [12,14] But at the core of the lost opportunity has been the lack of a relevant and rigorous national curriculum.

The supplement "Australian Curriculum Framework for Junior Doctors" published with this issue of the journal is a giant step forward in bringing much-needed national guidance for Australian prevocational medical training, and celebrates the launching of the

Framework by the Confederation of Postgraduate Medical Education Councils in October 2006. The Framework is the outcome of wide consultation with relevant stakeholders and is built on initiatives pioneered by the Postgraduate Medical Education Councils of New South Wales (now part of the NSW Institute of Medical Education and Training), South Australia and Western Australia, and was funded by the Medical Training Review Panel of the Australian Government Department of Health and Ageing. It also draws from the experience of the recently introduced "Modernising Medical Careers" Foundation Programme in the United Kingdom 15 and the Royal College of Physicians and Surgeons of Canada's CanMEDS 2000 Project. 16 The Framework, in essence, is a template for education and assessment of performance of junior doctors in the major areas of clinical management, communication, and professionalism (see Box).

The Confederation of Postgraduate Medical Education Councils and other relevant players are to be congratulated for making this defining document a reality. It shows what can be achieved with purposeful leadership and effective communication between key stakeholders. But there is more to do! The Framework has to be implemented Australia-wide in hospitals and in general practice. This will require commitment and support from the federal, state and territory departments of health, public hospitals, and general practice. Without this, nothing will change. These agencies need to acknowledge that investment in prevocational medical training now will yield dividends in health care safety and quality in the future. Prevocational educationust be a separate entity, not another health service add-on.

The need to assess the utility and impact of the Framework is self-evident: will it make a difference? Answers to this vital question will require the elaboration of discerning and measurable outcomes and processes for assessment. The article by Grant in the supplement (page S9) outlining initial experience in the UK with Foundation Years 1 and 2 of the Modernising Medical Careers Programme (the equivalent of our PGYI and PGY2) provides a valuable insight into what not to do: introduce a detailed determination of clinical competence based on multiple observed activities, in the face of insufficient resources and poorly informed and prepared participants. 18 Edmonds and Everett (page S20) outline the views of junior medical officers, registrars, and directors of clinical training on the Framework.[19] Junior doctors caution against failing to include affected stakeholders in its implementation, request that training positions be accredited, and believe that the Framework should be a promoter of teaching and not a barrier to vocational training or another checklist to complete. 12 Registrars and directors of clinical training believe that the Framework will add value and resources to current training systems, and improve support for international medical graduates entering the workforce.

We continually hear the descriptors "coordinated", "integrated", "assessment" and "accredited" applied to the medical training continuum, and to the casual observer it does appear to be a linked and orderly process. But with the expansion of our medical schools, current cracks in the continuum will become wide gaps. Questions now asked sotto voce will become fortissimo; questions such as:

- Will the medical education and training infrastructure be able to cope with increasing throughput? Despite teaching alternatives such as simulation, the experience garnered by extensive clinical exposure still remains crucial in medical training. [9]
- What are the core competencies of the new medical graduate? How are these to be tested?
- Should undergraduate and prevocational medical education and training be outcome-focused?
- With differing medical school curricula and assessments, should there be a common yardstick? Is a national qualifying examination overdue?
- Are current postgraduate training programs too long and inflexible?
- Should there be early vocational streaming?
- Should there be common basic training modules that are transferable between colleges?
- Should there be part-time and flexible tracks to cater for the lifestyle expectations of modern doctors, especially younger doctors and women?
- Should there be different competence ceilings for differing levels of specialist training?

And there are more.

Several experts have poignantly drawn attention to how the Australian medical training sector is fragmented and plagued by limited collaboration and coordination between relevant groups. 11,14 Underscoring this is the current situation: the medical schools have their

The Australian Curriculum Framework for Junior Doctors [12,17]

- The Framework is an educational template that identifies the core competencies and capabilities necessary to provide quality health care. It will enable individual doctors to assess their education and training needs.
- It outlines the general knowledge, skills and behaviour that prevocational doctors should acquire, regardless of their planned specialisation or training location.
- It bridges undergraduate curricula and college training requirements, and is intended to assist education providers, clinical teachers and employers to provide a structured and planned program of education for junior doctors.
- It is built around three learning areas - Clinical Management, Communication, and Professionalism-which are divided into varying numbers of categories and topics.
- Each category comprises a number of learning topics, each of which details the associated capabilities expected.
- It is envisaged that learning and assessment resources will be made available to support each learning topic.

representative body, Medical Deans Australia and New Zealand; the clinical colleges have an overarching body in the Committee of Presidents of Medical Colleges; and the postgraduate medical councils have the Confederation of Postgraduate Medical Education Councils. But despite their good intentions, all are virtual silos with limited interaction beyond their immediate spheres of interest. Is it not time that this insularity is broken down? If not, the drive for reform of Australian medical education and training may come from outside the profession in the form of an overarching government-regulated body 20 As a profession, do we really want this?

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Bravery In Admitting Vulnerability

Mukesh Haikerwal

The tragic, brutal death in June last year of Dr Khulod Maarouf-Hassan engendered many fears that we as doctors hold.

We are taught to he and we want to be accessible, and provide medical care, comfort and solace to many diverse and troubled people whom we call patients. There is an expectation from the community that we will provide care without favour. This obviously is our obligation and our responsibility.

But I think it is important for us to ask what is the responsibility that our patients have to us as part of this relationship?

Where do we draw the line when we are faced with misconduct, violent conduct, verbal or physical threats, or assault?

I recently spoke at the forum Your Safety Is In Your Hands at Monash University in Melbourne, sponsored by the Victorian Medical Women's Society.

The meeting was convened by Associate Professor Leanne Rowe, the Deputy Chancellor of Monash, and until recently the Chair of the Victorian faculty of the RACGP. Leanne has previously received the AMA's Best Individual Contribution to Health Care Award. She was involved in training Dr MaarOLlf-Hassan, and was her close friend.

Although the meeting wasn't specifically about this one tragedy, this barbaric act focused the participants' minds.

Dr Maarouf-Hassan's sister-in-law May Hassan asked us to not let this death be in vain, to learn from it, and to carry on the murdered doctor's flame.

Mukesh Haikerwal - President of the Federal AMA

To me, the standout comment of the evening came from the Head of Crime Prevention for the Victorian Police, Tess Walsh, who said there are three questions that we should all stop and ask ourselves.

- Number one: How many reports were made to the police in Victoria about violent crime in 2005? Answer; Just 17.
- Number two: How sick do I have to be before you as a doctor expect to see me? Should I be on my deathbed, should I be very unwell, or would you prefer to see me at an early stage?
- Number three: If you have panic buttons in your practice, when you press the button, what happens? If there's a noise, does it mean that the people who hear it should run away, or run to help".? Is it connected to the local alarm company or police station?

This last one in particular is a very important question.

What happens as a result of the precautions we put in place, and how can you make sure that the response is time-appropriate as well as appropriate in the circumstances?

The GP locum agency also had representatives at the forum.

They pointed out, quite rightly, that if you are aware of patients in

your practice who have engaged in violence or may he susceptible to violence, you should tell the local after-hours service, to reduce the risk of harm to other medical professionals.

The protocols produced by that agency - like many other pieces of research presented on the night - should really be collated and promulgated in due course.

A critical theme that emerged from the evening was that when a violent episode occurs, we should first turn the microscope on ourselves and ask; What have I done in the consultation that may have led to this outcome? This is

our self-doubt, and it is reasonable, but the event is often not of our doing. We must stop trying to excuse anti-social behaviour.

Another important contribution came from Dr Sandra Hacker, former Vice President of the Federal AMA, who made the point that not only are doctors very bad at looking after their own physical health, they're actually much worse at looking after their own mental health and seeking counselling and support.

She urged the group to seek such help when necessary.

Further food for thought came in recognising the pervasive attitude that to report violence is an admission of weakness.

I think we need to turn the tide.

We need to say that violence in any circumstances is unacceptable. We need to place notices clearly on our walls, and display clearly in the manner in which we approach our patients, the limit to which we are prepared to accept their upsets.

I was personally taken by a sign I saw in the Royal Melbourne Hospital recently clearly stating that physical and verbal abuse of the staff was unacceptable and would be reported to the police.

I think that was a very important message.

We need to say it's not okay to sweep this stuff under the carpet, it's not okay to allow violence to happen.
Rather than pretending it doesn't happen, it is actually braver to make sure that these incidents are documented and reported so they can be minimised or prevented from happening in the future.
A network of people who have a very real interest in this area is currently developing.
It is incumbent upon us as the AMA to bring this expertise together and provide clear, firm guidance as to what is and what is not acceptable, and how to deal with or minimise the risks of violent episodes - much as we've done around safe hours of work and safe handover.
This is a key issue for all health care workers. We need to ensure that we are safe, our colleagues are safe, and our patients are safe; in our own interests and in the interests of our families.

Australian Medicine, April 2 2007

Editor's Note:

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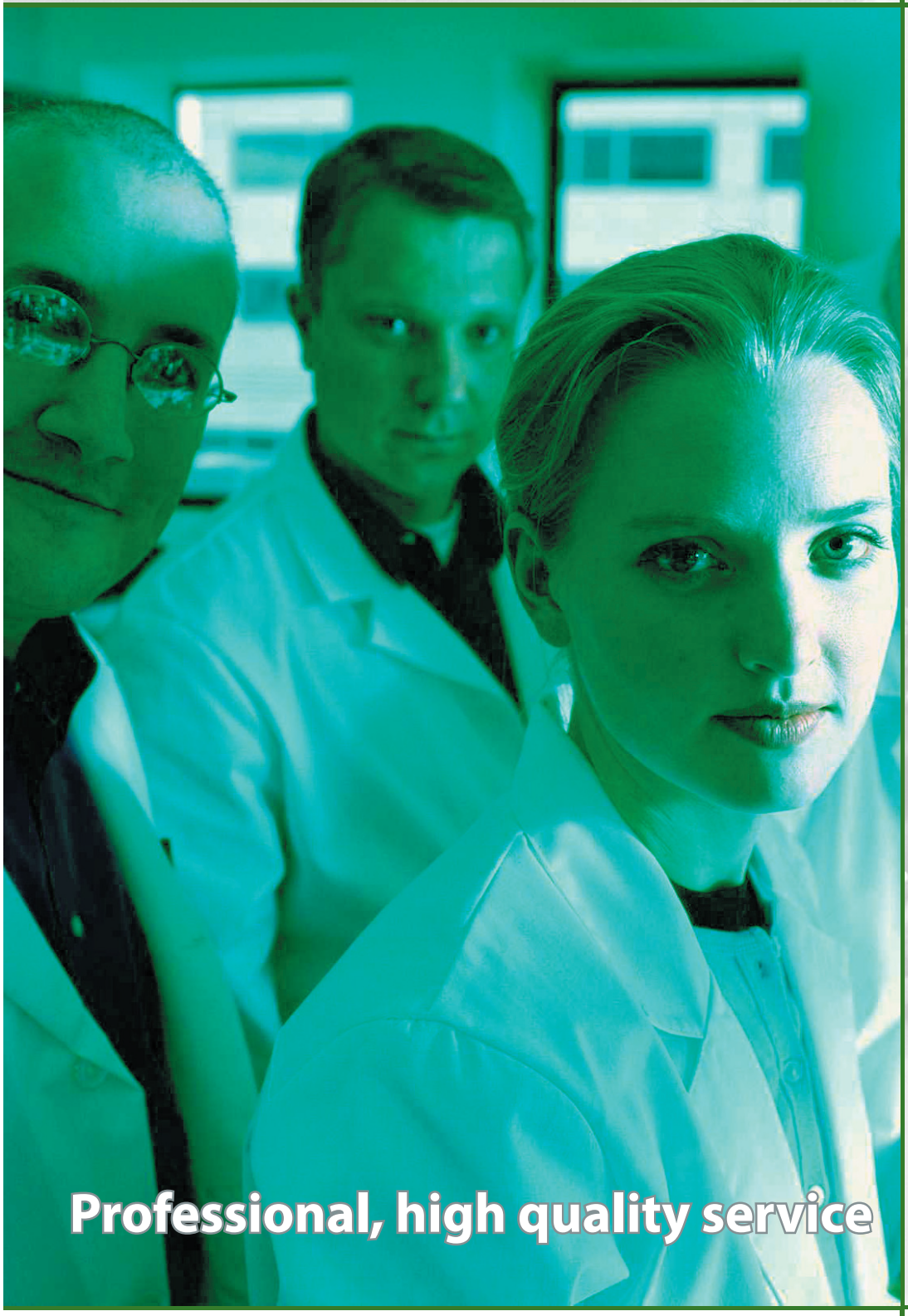

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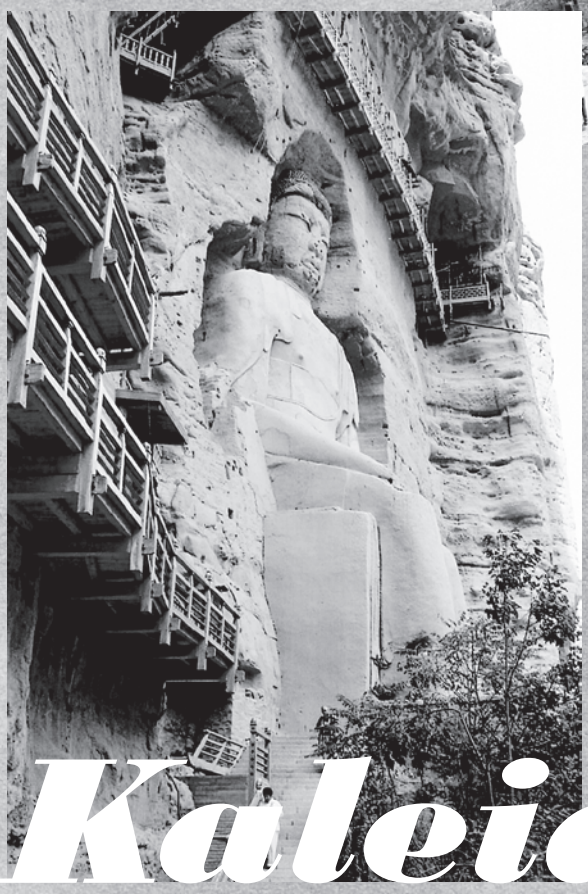


Kaleidoscope

The Girl from Ipanema

Min Li Chong

Tall and tan and young and lovely

The girl from Ipanema goes walking

And when she passes, each one she passes goes – ah

When she walks, she's like a samba

That swings so cool and sways so gentle

That when she passes, each one she passes goes – ah……

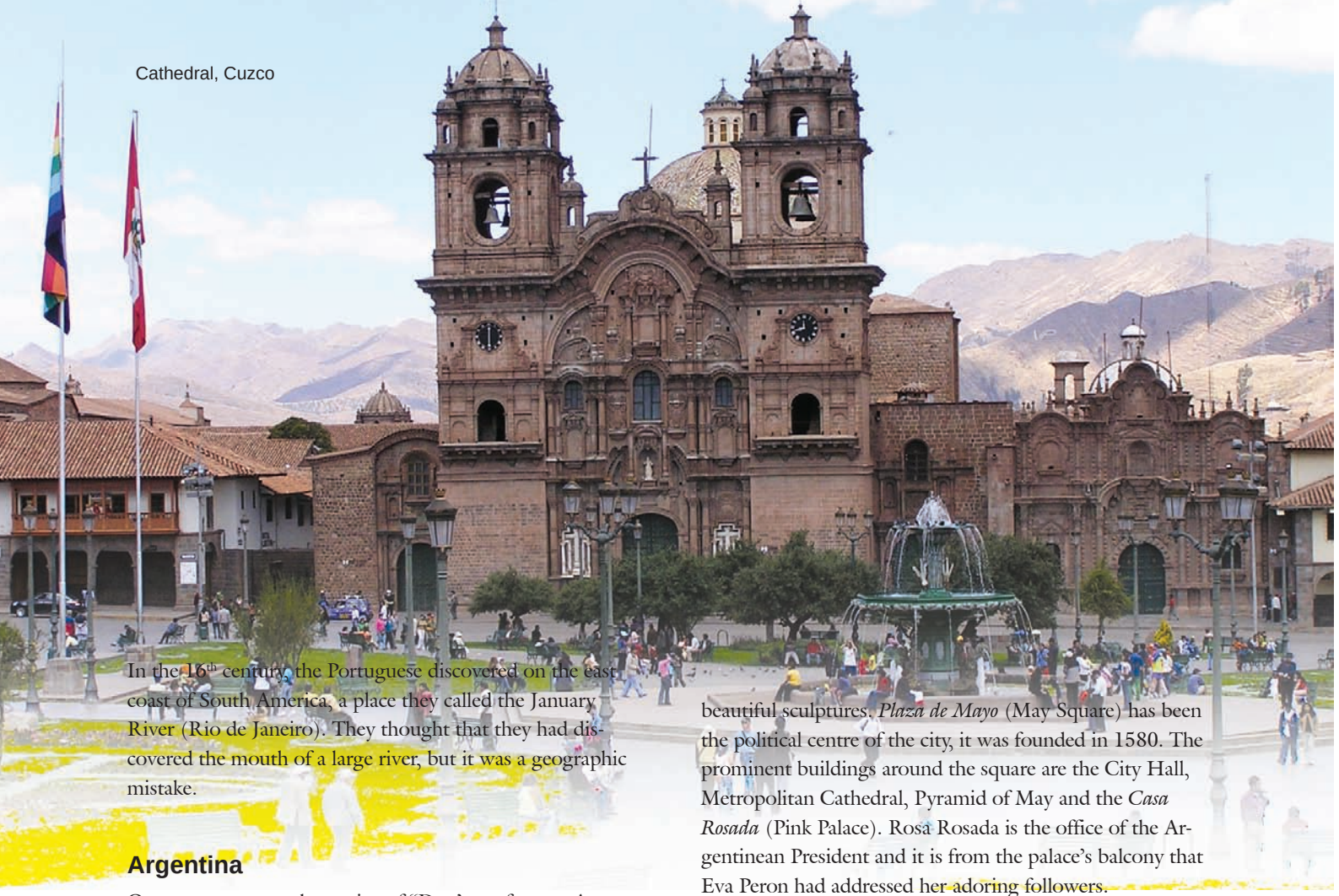
Brazil

I was on the look out for the girl from Ipanema, surveying the beaches for the bikini clad girl or girls from Ipanema. A body shape for me to aspire to? We were in Rio de Janeiro, Brazil. Rio was hot and humid, ideal for the beach scene. Rio de Janeiro is well known for its beaches - the Copacabana, Ipanema and Leblon beaches which face the open Atlantic Ocean. One can watch or play volleyball, beach soccer, hand shuttle and surfing, build sand castles or just watch people walk by. Ipanema beach was famous among Brazilians even before Antonio Carlos Jobim wrote his famous song and Vinicius de Moraes the lyrics. Rio is also well known for the statue of Christ the Redeemer with its arms outstretched, looking over the city. The Christ the Redeemer or *Cristo Redentor* is a stylish Art deco statue, standing 30 metres high on top of the Corcovado Mountain which is 710 metres above sea level.

Brazil is the birth place of the samba and Rio is the place for the Carnaval. With the rhythm of the samba and shimmering skinny costumes of the Carnaval, it is the biggest party in the world. The parade is over two nights, an all night parade of dance to the rhythm of samba, and floats. Originally, Carnaval marked the last few days before Lent, which is forty days before Easter. Unfortunately it was not Carnaval time when we visited Rio but we did drop by briefly at the Sambodrome, a mile long concrete parade ground in the centre of Rio especially built for the event. Other highlights of Rio are the Sugar Loaf Mountain, Petropolis, and a spectacular samba show with singers, dancers presenting Brazil's folklore, capoiera (Brazilian martial arts) and carnival rhythms. Then there is shopping for precious stones, with lots of bargaining skills required or a degree of resistance against extreme persuasion. Just in case you wanted to know, it was way above my budget!

Petropolis is only an hour away from Rio, a mountain resort and a favourite weekend away for the residents of Rio especially during the summer months to escape the heat and humidity. Petropolis was the summer city of the Emperor Peter. The Emperor built his summer palace in the 19th century which is now the Imperial Museum. It now houses a collection of art and jewels including the imperial crown jewels. Sugar Loaf is a mountain, named by the Portuguese as *Pao de Acucar* (Sugar Loaf). During the height of the sugarcane era in Brazil during the 16th century, liquid was placed to set in conical moulds, whose shape resembled that of the famous mountain. To get to the top of the mountain which is 270 metres high, one takes a two-stage cable car up. The first stage is *Morro da Urca* with 170 metres, with a restaurant, amphitheatre and a helipad. The second stage goes to the top of Sugar Loaf, which has the view of the entrance to Rio's harbour and the Guanabara Bay.

Brazil is a federal republic and is divided into 26 states and one federal territory. It is the fifth largest country in the world with a population of 160 million. Brazil borders all South American countries except Ecuador and Chile. Its largest neighbour is the Atlantic Ocean with its coastline of more than 9,000 kilometres. From east to west, the widest extension of Brazil is 4,300 kilometres and from north to south Brazil stretches almost the same in length. The northern part of the country is dominated by the Amazon, the tropical rainforest. Rio de Janeiro is situated along the country's south coast with a population of seven million.



Cathedral, Cuzco

In the 16th century, the Portuguese discovered on the east coast of South America, a place they called the January River (Rio de Janeiro). They thought that they had discovered the mouth of a large river, but it was a geographic mistake.

Argentina

One cannot escape the strains of "Don't cry for me, Argentina". The music was written by Andrew Lloyd Webber with lyrics by Tim Rice for the musical "Evita" in 1978. The song has been recorded by many artists including Elaine Paige, Sarah Brightman, Olivia Newton John and Madonna. Juan Peron and his second wife, Eva rose to power at the end of the Second World War, supported by the working class who were demanding a better life and opportunity. Peron was in power for nine years and his power was brought down by a coup in 1955. Eva Peron died of cancer at the age of 33. She is buried at *Cementerino de la Recoleta* in Recoleta, one of Buenos Aires' prime tourist attractions. The cemetery was created in 1922 and is the oldest in the city. It covers four city blocks and has more than 6,400 mausoleums with different architecture including Greek temples and pyramids and numerous beautiful sculptures. *Plaza de Mayo* (May Square) has been the political centre of the city, it was founded in 1580. The prominent buildings around the square are the City Hall, Metropolitan Cathedral, Pyramid of May and the *Casa Rosada* (Pink Palace). Rosa Rosada is the office of the Argentinean President and it is from the palace's balcony that Eva Peron had addressed her adoring followers.

Buenos Aires is the capital of Argentina, with a population of 33 million, accounting for 40% of Argentina's population. It is a major port city and massive immigration from Europe gives the city a cosmopolitan atmosphere. Its main influences are from Spain and Italy. It is well known for shopping, leather goods, tango and meat. Residents of Buenos Aires are known as Portenos. They dine late at about 10 pm and the nightlife does not start till after midnight. Argentina is a great exporter of meat and there are plenty left over for the country. Hence, the meat is best

Pink Palace, Buenos Aires

Variety of corn

Iguazu Falls

eaten barbequed or grilled. I have never eaten so much red meat in such a short space of time. Another popular custom is drinking *mate*, a tea made from the yerba mate herb. The tea is served in a gourd, passed around the table or group with each person sipping through a metal straw. The person who mixed the tea first will take the first drink as it is at the most bitter. The major avenue in the city is the *Avenida 9 de Julio* (Avenue 9 July) marking Argentina's Independence Day, from Spain. It is the widest street in the world and stretches into highways from north to south.

Some of the main attractions of Buenos Aires are La Boca, *estancias* (farms), and of course Tango. La Boca is a colourful suburb, located south of the city. Most of the streets are cobbled with high sidewalks designed to preserve the residents from the floods in the early days. The homes of the Genoese immigrants were built of corrugated iron and wood painted in striking colours. We visited *Estancia Santa Suzana* which is an hour's drive from Buenos Aires. It is a working cattle station owed by a wealthy Argentinean Irish family and had a beautiful lunch with lots of meat and watched the gauchos demonstrate their horse riding skills. One of the unexpected highlight was a wonderful delicious authentic Fu Chow Chinese feast in Buenos Aires.

Tango is Buenos Aires. Tango originated with a guitar and violin towards the end of the 19th century in brothels and was first danced by the working class in La Boca, San Telmo and the port area. With increasing waves of immigrants meant tango eventually made its way to Europe and it was internationalised in Paris. Rudolph Valentino made the Tango a hit in 1921. With European approval, the Argentine upper and middle class took to the dance as their cultural identity. Astor Piazzola furthered the cause of tango, incorporating some classical elements. Tango involves various forms of expression in music, poetry and dance. The latest style is electric tango, a modern adjustment to the dance which is popular amongst the younger Portenos.

Argentina is the world's eight largest country covering more than a million square miles. It is bordered by Bolivia, Paraguay, Brazil and Uruguay in the north and the Chile on the west.

Iguazu Falls

The falls are on the border between Argentina and Brazil. The Iguazu river basin collects water over a large area in Brazil, which falls over the geological fault just before the river flows into the Parana River. The falls are located in the *Parque Nacional Iguazu* on the Argentinean side in the subtropical jungle setting. There are numerous walkways to view the various waterfalls from above, the walkways and paths blend in well with the jungle. The park is also a wonderful place to see the area's fauna and flora. We were

Group in Peru

fortunate to stay at the Sheraton International Iguazu Resort located in the national park. The hotel is located only metres from the Upper and Lower Circuit trails and most of the rooms have a direct view of the *Garganta del Diablo* (Devil's Throat) waterfall. The Devil's Throat is the biggest and highest of all the waterfalls, which is visible on both sides of Argentina and Brazil national parks. The roar and power of the waterfall as the water falls over a sheer precipice is exhilarating and refreshing in the subtropical heat. While most of the falls are on the Argentinean side, the view from the Brazilian side gives a different and lower perspective.

Peru

We were entertained at almost every meal by musicians on pan pipes and drums playing *El Condor Pasa*. What is *El Condor Pasa* to the Peruvians? *El Condor Pasa* is a Peruvian musical play but it is more famous for a title song. In 1993, the piece was declared as an official part of Peru's cultural heritage. The music was composed in 1913 by Danial Alomia Robles, inspired by traditional Andean songs with lyrics composed by Julio Baudouin. The lyrics are in Quecha, the language of the Inca Empire which is still spoken by the indigenous people of Peru. The singer calls on the mighty condor of the Andes to take him back to the old Inca Kingdom of Machu Picchu. It is the best known Peruvian song worldwide due to a cover version by Simon and Garfunkel in1970. Paul Simon only used the melody and wrote entire new lyrics for the melody.

Peru lies just below the equator and is the third largest country in South America. It shares borders with Ecuador and Colombia to the north, Brazil and Bolivia to the east and Chile to the south. Peru has a population of 26 million with 8 million in Lima, the capital of Peru. Spanish is the official language of Peru. 30% of the population still speaks the language of Quecha, mainly spoken in the highlands.

Peru has two large groups of immigrants of Japanese and Chinese. There are lots of *chifa* restaurants which are Peruvian-influenced Chinese restaurants. Guinea pig is a delicacy in Cuzco and is available at a reasonable price – it comes roasted or fried served with the body upside down with head and feet intact. Alpaca steak is also recommended. Local drinks to taste are the pisco sour, Inca Kola and the *chica morada*. The pisco sour is a cocktail mixed with pisco (white grape brandy), egg whites, lemon juice, sugar and bitters is Peru's margarita. Inca Kola is Peru's well known soft drink and *chica morada* is a non alcoholic purple drink made from blue corn. Cuzco and the Sacred Valley is also a wonderful place for shopping for textile, handicrafts, and alpaca products.

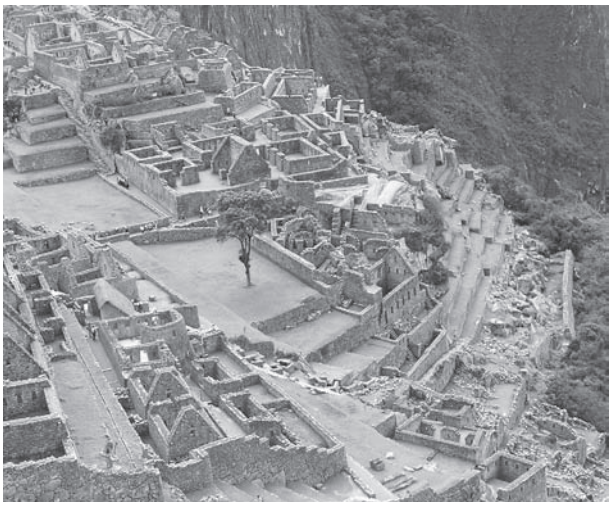
We flew to Cuzco, which was only an hour's flight from Lima. Cuzco was the capital of the Inca dynasty and the gateway to Machu Picchu. Cuzco is a colonial city built on the foundation stones of the Inca palaces. As it is situated at 3,400 metres, the air is noticeably thinner and altitude sickness is common to newcomers. Headaches and breathlessness are common symptoms. Rest, fluids and the coca-leaf tea (known to thin the blood) are recommended and sometimes a good dose of sugar or chocolate definitely perks one's ability.

Attractions in the Cuzco are the Plaza de Armas, *La Catedral* which is built on the site of the palace of Inca king Viracocha with its beautiful woodcarvings, altar and paintings, the *La Compania de Jesus* church and *Qoricancha* (Temple of the Sun) and Santo Domingo. *Qoricancha* which is Quecha for "golden courtyard" was covered with gold in the Inca period. This temple forms the base of the colonial church of Santo Domingo. There are four ruins around Cuzco: Saqsaywaman – which was of religious and military importance; Puca Pucara - which was an Inca rest house; Tambomachay - known as the Baths of the Incas; and Qenko - an underground cave and temple.

The *El Valle Sagrado* (Sacred Valley) is 600 metres lower than Cuzco; it is beautiful valley on the way to Machu Picchu. In the valley, there are many smaller Inca sites. We passed by picturesque towns like Pisac with its famous handicraft market, Calca, Yucay, Urubamba and Ollantaytambo. Ollantaytambo was a military, religious and agricultural centre. Its stone fortress is located on the highest part of the mountain built by Pachacutec; and it had protected the valley from the invaders. It has a wonderful view of the Urubamba valley and the view of the town from the top was breath taking. The town is a living Inca town with its narrow streets and water channels which are still in use by the locals. We caught the Vistadome train to *Aguas Calientes* (Hot Springs), as the Ollantaytambo train station is half way between Cuzco and Machu Picchu.

Aguas Calientes, known as Machu Picchu Pueblo, is situated in the valley below Machu Picchu. Most travellers pass through the town on the way to Machu Picchu. We stayed at Machu Picchu Pueblo Hotel, an excellent hotel worth a mention with wonderful food and surrounds. It is known for its eco-tourism and offers orchid tours, bird watching and guided ecological walks.

Machu Picchu is the greatest attraction in Peru. Machu Picchu is the name of the mountain where it is located; it means "Old Mountain". Its real name is unknown, lost with the last surviving Incas who had lived there and later abandoned the city in the 16th century. It lay dormant for more than four centuries and is located at about 2,400 metres above sea level. Machu Picchu is located on a green saddle between high peaks, situated in the Vilcabamba Mountain chain over the Urubamba River. To reach the site, small buses run by the national park start from *Aguas Calientes and* climb the steep and twisting road around 22 hairpin bends up the mountain. Machu Picchu can also be accessed by the hiking the Inca trail - the ancient royal highway, which is more suitable for the fit tourist. It was rediscovered by Hiram Bingham in 1911, an American archaeologist. Known as the "Lost City of the Inca", it is steeped in mystery and folklore. It is believed that Machu Picchu was built during the reign of Pachacutec, the empire builder of the Incas. It appeared to be a ceremonial and agricultural centre. The complex has steep terraces for agriculture with aqueducts carved out of the hillside, guard houses, limestone temples, dwellings and staircases. It is a wonderful exhibition of stone masonry and design. It is the only significant Inca site to escape from the destruction of the Spanish conquistadors in the 16th century. This was mainly due to the fact that the Spaniards never reached Machu Picchu. It is a photographer's paradise but neither pictures nor words can describe the atmosphere the complex generates. This is definitely the real jewel.



Machu Picchu, Peru

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Machu Picchu, Peru

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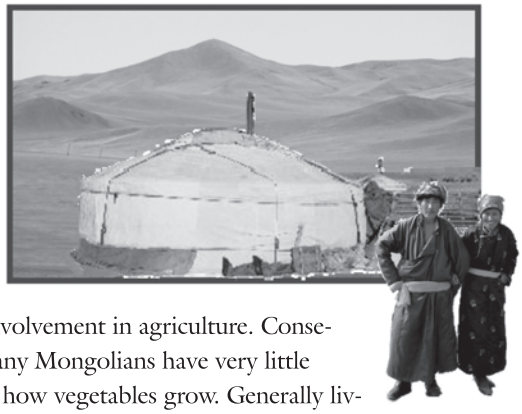
In the Shadow of Genghis Khan…

Robert Gan



About 800 years ago, under the great Genghis Khan and his grandson Kublai Khan, Mongolia ruled the largest empire the ancient world had ever seen – stretching from the Pacific Ocean in the east, to the middle of Europe in the west. Outer Mongolia today, is just a shadow of its former glory with a population less than that of Melbourne and a GDP ranking at 143 among the poorest nations of the world.

Mongolia is a poor country with more than a third of the people unemployed. Almost half of the people are nomadic herdsmen, constantly on the move to find pastures for their flocks and herds. These people live in small, portable, tent-like homes called "gers". The gers have none of the facilities that we here in Australia take for granted – gas, electricity, running water, toilets etc., and even those who live in the villages and towns do not have running water.

The staple diet in the rural communities is fatty mutton, fermented horse milk and wheat when it can be obtained, and salty tea. Because of their nomadic lifestyle there is minimal involvement in agriculture. Consequently many Mongolians have very little concept of how vegetables grow. Generally living conditions are primitive and this is reflected in the health of the people. There is a great need for health education in nutrition and agriculture, and for medical/dental treatment in the rural communities.

Outer Mongolia was under the Russian government for the past 70 years, and it was only after the fall of the Soviet Union, that Outer Mongolia gained independence. The fledgling nation struggled to restore what was left of the country, with donations from the richer neighbours like China, Korea and Japan. More than half the population is under the age of 30 years –so it is a very young nation. Unemployment is very high.

The capital of Outer Mongolia is called Ulaan Baatar (the Red City). It is a thriving city with many imported western consumer goods. The Russian influence is reflected in many of the buildings and statues that guarded each government institution. The infra-structures like electricity, hot water, paved roads and telecommunications have much to be desired, and progress in these areas is painstakingly slow.

Surprisingly in the capital city, there are quite a large number of hospitals, many of which were built by foreign countries to serve their expatriates living there. There is an apparent distrust of the Mongolian medical service by the expatriates living there.

The Mongolian University Hospital is located next to the teaching university, and is the general hospital for the country where most

Robert Gan
Dental Surgeon; Nutritional & herbal medicine practitioner; A/Prof, Dept of Orthodontics, Royal Dental Hospital

of the medical specialties are located. Most of the medical equipments are Russian built and many have gone pass their use-by date. Despite the many hospitals, there is a critical need for quality pharmaceuticals and medications. It is a very common practice for the medical staff to substitute medications when the indicated ones are not available.

In the rural communities the medical and hospital scenarios are worst. Many rural medical staff is poorly paid and the hospital facilities antiquated. Again there is a critical need for quality pharmaceuticals and medications. Under the previous Russian medical care system, there is free or subsidized medical treatment for all Mongolians. In each rural township, there will be a hospital containing medical and dental facilities.

The town called Moron (pronounced as Muren in Mongolian)

This is a little country town of population 40,000 located in the far northwest corner of Outer Mongolia, in a region now called Siberian Mongolia. It is very isolated from the rest of Mongolia by vast stretches of steppes and desert. Most of the people are herdsmen and they moved from oasis to oasis in search for grasslands to feed their flock.

The people from this particular town are from the ancient tribes of Tartars and Kazaks.These folks are classed as second rated by the city rulers who are from a different tribe. The support from the central government in every aspect of the township is poor, slow and the 'waiting game' is in vogue.

There is a Russian built hospital in the town centre, and the medical/dental facilities are supposed to serve a radius of many thousand kilometres with many hundreds of roving nomads. With the existing poor salary scale, it is impossible for the medical/dental staff to upgrade their education, let alone going overseas for conferences and seminars. The infra-structures like electricity, hot water and sanitation are primitive and erratic, as blackouts are a common daily occurrence.

This hospital and the medical staff certainly need modern hospital beds and equipments especially in the physiotherapy department, a good supply of latest medical journals (in the Russian language) and an in-service training and upgrading program provided by overseas medical experts.

Because of the scarcity of water in this region, there is a desperate need for a city wide education program in personal, health and dental hygiene.

How I got involved

A couple of years back, I responded to a call for a dentist to join World Vision & ADRA in a fact-finding expedition to Outer Mongolia, to determine the human needs of the rural Mongolians. I was very much impressed and touched by the kind hospitality of these gentle people.

Part of the expedition includes a tour of the hospitals in the city and in the rural communities, as well as a couple of night's stay in a typical Mongolian rural commune. We also had a mini conference with the Minister of Health and the Minister of Education in Ulaan Baatar.

Many of these rural Mongolians come from a different tribal background to the city bureaucrats, and through the help of interpreters, our team heard first hand the frustrations faced by these rural folks in terms of getting proper medical and dental care in outlying regions.

In consultation with our team members, most of us felt that establishing a mobile medical/dental clinic would best serve these rural communities.

Upgrading the medical facilities in the rural hospitals would also help.

Health education programs can be worked with the help from the local councils.

Finally, teaching the local folks how to grow vegetables in green houses would be a worthwhile novelty.

So I'm here in Australia, raising funds for these projects, and collecting good hospital beds and medical/dental equipments that can be sent up to Outer Mongolia.

The Old Silk Road

Frank Teoh

Silk Road begins here Xian - the author and his wife

Xian city wall

My wife and I decided to go on a group tour of the Old Silk Road, China, in September 2006. The tour started on the 13th of September and ended on the 4th of October. There was an optional three- days tour of Beijing as well as an optional three -day extension to Tokyo on the return segment.

The whole tour was expertly organised and we were accompanied by Gina Goei and her husband Richard, of All World Travel Melbourne. For the China segment there were local English speaking guides who were on the whole competent and affable.

The Melbourne travel agency prepared for all the travellers a specific booklet for this tour with all the information that may be reasonably required, such as itinerary, phone numbers and general facts about travel in China.

"Why go along the old silk road ?" you might ask. We went, to experience the rich culture and history of China, both ancient and modern, and to explore her relationship with other civilisations.

Preparation to attain a certain level of physical fitness is required for this trip. If one can walk for one hour a day before the trip, one should be able to cope. Of more importance is the need to be aware of altitude sickness.The Heaven Lake in Xijiaang, at 2000 metres altitude, should not be difficult for someone without major heart or haematological problems. A visit to the Tibet monestary in Xiahe, at 3000 metres, left me breathless with palpitations (I have a blood problem).

To avoid undesirable medical problems during your trip to China, a pre-travel health check is essential. In particular, there are a few relevant vaccinations to receive. It is worth bringing along your own medications, and a course of anti-diarrhoea pills and sachets of gastrolyte solution would be wise.

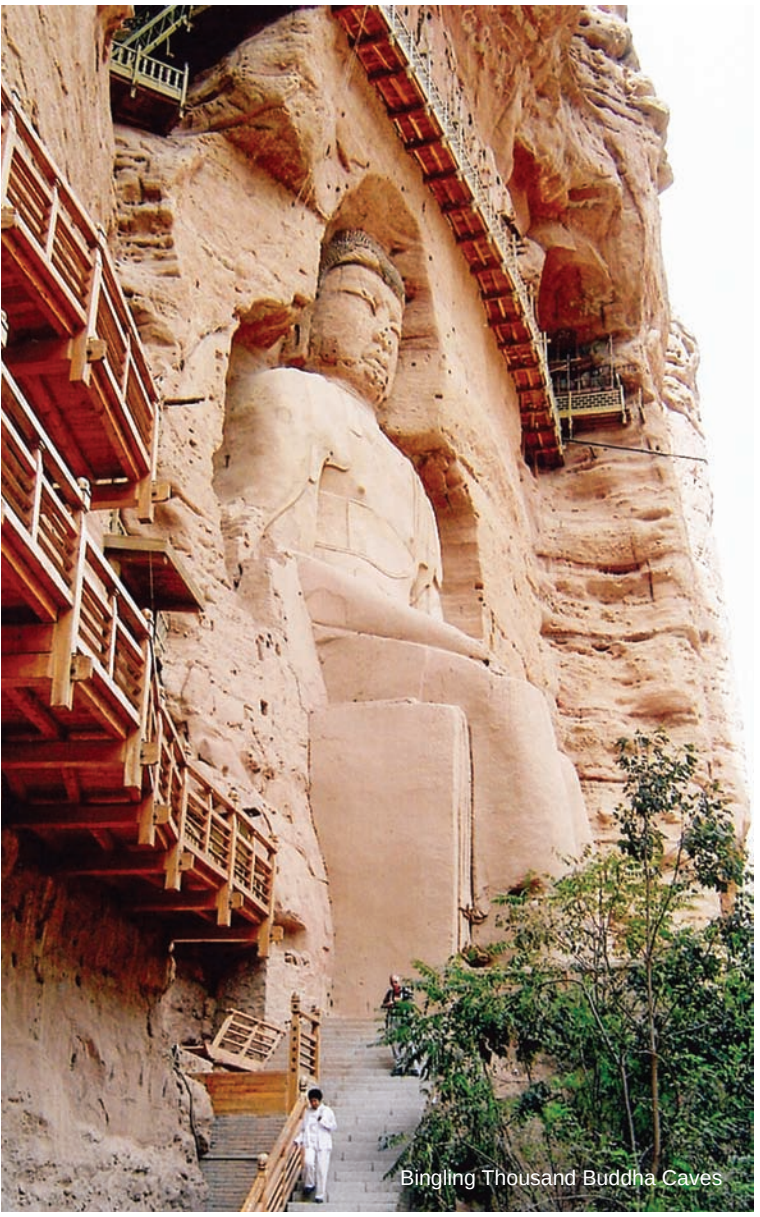
The itinerary includes a night's stay at Hotel Niko Nrita , complementary of the airline. We found the service punctual and satisfactory.

The next day we flew to Xian, the ancient capital of China.

Xian Terracotta Warriors

Big Wild Goose Pagoda

Water Wheel - Yellow River, LanZhou



Bingling Thousand Buddha Caves

Bingling, arrive by boat here

We spent three days in Xian seeing the sights, amongst which were the complete remains of the six thousand years old "Banpo" village which practiced the matriarchal society. We toured the Big Wild Goose pagoda which holds historical significance to Buddhists in China. We then visited the Muslim quarter in the city where there are enclaves of people of minority ethnicity in Xian. The Huaqing hot spring was the scenic paradise for one of the Tang emperors and his favourite concubine. We toured the Hanyang museum/tombs, a twenty square kilometre burial area reserved for the Han emperor, his family and officials.

On day four of the tour we travelled by overnight train to Lanzhou, the capital of Gansu province which is more rural than Xian. This is the location of the Yellow river which is believed to be the birth place of the Chinese nation We took a cruise along the river in rafts made from lambskin, saw a series of water wheels on the banks and wonderful scenery.

We visited two major areas of Lanzhou which were rich in legends and the renown Binglisi rock caves with giant Buddha statues carved into the cliff face. To approach the caves it took a two hour ride in a speed boat in the second largest dam in China (60 kilometres long and 4 kilometres wide). A bus ride up the scenic Jishi mountain pass to Xiahe took us to the Tibetan Buddhist monastery, residence of the Yellow Cap sect. We spent the night in the mountains on the nomadic grassland and rolling pastures, and our stomaches were warmed by a typical Mongolian dinner. Altogether, we spent four days in Lanzhou and its surrounding areas.

The next stop on an ever westward journey was the strategic pass called Jiayuguan, with massive fortifications guarding the Hexi corridor. Next we visited the fascinating tombs of Wei and Jin dynasties in the Gobi desert - tombs of wealthy families living in these areas thousands of years ago. Well preserved bright paintings on the walls surrounding the burial chambers depicted seasons or daily life including farming, house hold activities, weddings and the like.

The last stop of the trip for us was Dunghuang, site of the world heritage listed Moggao Caves – the series of Buddhist sculptures and murals dating back several dynasties. This is a manifestation of religious passions among Chinese people. I had to terminate the trip here because of severe gastroenteritis and admission to the local hospital for treatment. The group continued onto Turpan, Kurla, Kuga, Aksu in the Gobi desert. and finally Kashka where the world's largest open-air Sunday market is held.

From there they proceeded to Urumuqi, the capital of Xinjiang province, to visit the famous Heaven Lakes and Municipality Museum where 1000 year old Caucasian skeletons are preserved and exhibited.

In conclusion this Silk Road tour is a fascinating adventure and is well worth doing.

Tai-Chi: An Exercise of Body and Mind

Boon Hung Hong

Tai-Chi literally translates as '*the grand ultimate*'. It was created as an ultimate martial art to counteract the all-powerful Shaolin martial arts. It is said that Tai-Chi was created more than 800 years ago by a Taoist, Master Zhang Sanfong, who himself was an expert in Shaolin martial arts. Master Zhang created Tai-Chi after he witnessed a fierce fight between a snake and a crane in his backyard, where the cunning snake twisted and hissed, avoiding the powerful speedy strikes from the crane's beak. Much like the snake, Tai-Chi utilizes soft, twisting and resilient forces to conquer the powerful speedy strikes of Shaolin, which resembles the crane's beak.

Initially, Tai-Chi was passed on secretly from one master to selected disciples. About 300 years ago, during the late Ming or early Qing dynasties, General Chen Wanting, a garrison commander in Wenxian county, Henan Province, created Chen style Tai-Chi. He passed on the art only to his sons and grandsons. Later on, Yang Luchan (1799-1872) of Hebei Province learned the art of Tai-Chi from Chen Chang-Him (1771-1843), a descendent of Chen Wanting, and devised his own Yang Style Tai-Chi of today. In 1852 Yang Luchan brought Tai-Chi with him to Beijing. Later on Wu Jianquan (1870-1942) a disciple of Yang Luchan's son created his own Wu Style Tai-Chi. Today we have Chen, Yang, Wu, Wo and Soon styles of Tai-Chi.

The Tai-Chi martial art consists of a set of floor exercises, pushing hands, qigong (a system of Taoist deep breathing exercises) and skills in weaponry. Its practice is in contrast to the speedy and jerky movements of the Shaolin style of martial arts. From a physiological point of view, Tai-Chi can indeed help to improve and regulate the function of various body systems in the following ways:

a. Improving the Cardiovascular System

Tai-Chi floor exercises consists of a set of slow continuous flowing movements. It is often referred to as 'swimming on land'. Body posture and balance are maintained throughout the whole set of exercises. Upper and lower limb movements are coordinated and relaxed according to the flow of power. There are no sudden jerking movements. This enables the heart to beat at a constant and steady rate, which, by improving blood circulation to vital organs, encourages cellular metabolism. Cardiac muscle itself also receives a constant blood flow and oxygen supply, thus improving its function. Theoretically Tai-Chi is an excellent exercise for sufferers of ischaemic heart disease. It has been shown that blood pressure drops slightly during Tai-Chi floor exercises.

b. Increasing the Vital Capacity of the Lungs and Improving the Digestive System

Tai-Chi Qigong is a system of deep breathing exercises coordinated with limb movements. Diaphragmatic muscles contract and relax in conjunction with abdominal muscles in order to transfer power or Qi or Jin from the foot to the palm or finger tips when striking an opponent. After completion of the whole set of Tai-Chi floor exercises, one would perspire profusely with a warm feeling in the palms. Yet respiratory rate remains normal and controlled without the puffing or shortness of breath experienced in other forms of strenuous exercise. Over time, practice of Qigong improves lung function by increasing the vital capacity. Tai-Chi is therefore beneficial for asthma and COPD sufferers.

Boon Hung Hong
Consultant Surgeon
Tai-Chi Master in Charge of Integrated Yang Tai-Chi Association of Australia




During this slow exercise, the diaphragm descends simultaneously with the relaxation of abdominal wall muscles, leading to movement of the abdominal viscera. Theoretically this should improve digestion. One should not practise Tai-Chi after a big meal.

c. Improving Lumbar Back and Reducing Falls

From a fighting science point of view, Tai-Chi utilizes circular movements to deflect powerful oncoming forces and uses tangential forces to strike back. The complete set of floor exercises and pushing hand techniques are meant to train the practitioner to fight with this ability. Tai-Chi is about skill rather than brute force. To achieve this, one must drop the shoulders and elbows, maintain correct head and neck posture, relax and contract lumbar muscles in conjunction with hip joint movements, and use the mind to guide these movements. Good head and neck posture helps to strengthen the trapezius muscle at the back of the neck, and erector spinalis muscles of the back. This practice of smooth movements and good posture certainly helps people with chronic lower back pain and neck pain.

In addition, as Tai-Chi is a weight-bearing exercise, prolonged practice leads to increased bone density. In conjunction with this, improved proprioception and control of muscles required for balance significantly reduces the risk of accidental falls, and therefore reduces ones chances of fracturing their hips in old age.

d. Mood and Well-being

During the practice of Tai-Chi, the mind should remain clear and focused solely on the movements, akin to 'meditation in motion'. One should achieve relaxation, contentment and a warm inner feeling after Tai-Chi. The practitioner should also experience an improvement in mood and relief of tension.

Prolonged and correct practice is required to achieve all of the beneficial effects of Tai-Chi.

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I'm beginning to discover that there's no such thing as a quick trip down to the Lexus dealer. When Mrs Shaft said, "How long will you be?" I didn't take account of how much new technology there was to learn about in the new GS450h. After last road-testing the GS430 in May 2005 I thought that I knew my way around the car, but there are mountains of new gadgets built into the GS450h. For starters Lexus have taken out the excellent 208 kW 4.3 litre V8 from the GS430 and dropped in a lighter 3.5 litre 218 kW V6.

You wouldn't need to be a mathematician to realize that this should be good for performance, but the 450h has another trick up its sleeve. Somewhere under the bonnet they've also slotted in two electric motors pushing out another 147 kW. At this point it's worth remembering that it wasn't that long ago that a V6 Commodore once produced 125 kW so Lexus owners shouldn't need to be worried about the size of their appendage. Lexus reckon that this combination somehow all adds up to 254 kW of what they call "total system output". Anyone needing confirmation that the car is storing energy when it coasts downhill or brakes can check the on-screen display for an environmentally friendly read-out.

So how does the GS450h go? Well on paper it goes from 0-100kmh in 5.9 seconds which is 0.2 seconds faster than the GS430. But to really appreciate its performance Mrs Shaft took it up the Somerset Drive hill climb. Forget about Baldwin Street in Dunedin NZ, Somerset Drive on Buderim (Qld) just happens to be the steepest street in the World and its slope bears an uncanny resemblance to the wall of the nearby Somerset Dam. With the electric motors boosting the torque the GS450h just kept on accelerating all the way to the top. And Mrs Shaft was quick to point out that the electric motors re-charge the batteries on the way back down. Best of all though is that all of this wizardry saves fuel with the 450h using 30% less fuel than the GS430.

On the down side storing all that power does take up most of the boot space and there wouldn't be room back there for more than one set of golf clubs. The dealer told me the energy storage unit is just like 240 NiMH mobile phone batteries and costs about $1,000 to replace every ten years. The extra propulsion also does add a hefty 235 kg in weight, but this is more than overcome by better performance and 30% better fuel economy. The only sour note in the GS450h equation is the fact that US motorists can buy one for $47,000 less than in Australia. And they save even more when you subtract the US Hybrid Federal Tax Credit which is worth about $2,000.

So if the GS450h is faster and $15,000 cheaper than the GS430, who'll be buying the GS430 from now on? I had my local Lexus dealer stumped for a minute. Then he said, "Well some people play golf and some people just want a V8!"

I say, "Good luck to them".

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3/1310 Centre Road , Clayton South, Vic 3169 Tel: 9545 5688

Ferry Rusli

Is there a good Thai restaurant in the south-eastern suburbs? Yes, River Kwai is definitely on the list for the top 3 Thai restaurants in Melbourne. Most restaurants in my guide have been around for more than 4 years with no change in the cooking personnel / owners and more importantly I have tried at least 90% of the food (over at least 10 visits at various times of the week to assess consistency). River Kwai is mainly Thai with a small selection of Burmese curries in the menu. It is small (seats 58) but it has a nice relaxed ambience. The owners are Julia Phahonvanich (Thai & main chef) and Vincent (Burmese). Julia's three sisters also help with the running of the restaurant (1 in the kitchen & 2 on the floor). They are ably assisted by at least 3-4 friendly attentive waitresses on most nights.

The food in River Kwai is prepared with fresh ingredients with no short-cut from bottled sauces etc. The Tom Yum seafood pot ($40 for 4-6 people) is an excellent starter with adequate spiciness from chillis (not overpowering like some other restaurants), sourness from tamarind juice / tomatoes and the fragrant of lime leaves / coriander. The seafood content of the soup includes blue swimmer crab (which gives the soup extra flavour), prawns (they are big but sadly they are crunchy with bicarb like most other restaurants in Melbourne—for those **true** prawns lovers, you will know what I mean!), mussels, pippis, fish fillets and squids. They also have individual servings of various Tom Yum soup (chicken & prawns).

Salads are the next highlight of River Kwai. My favourite is Som Tum (young green papaya salad), very refreshing, crunchy and sour enough for my liking (I prefer sour / salty rather than sweet). Their version is comparable to the ones on the streets of Thailand and it will improve your appetite. Other notable salads are the seafood salad with glass noodles or the Larb Nir (medium rare beef rump served with lime juice, chilli, mint leaves & toasted spices - yummy!).

Main courses in River Kwai are dominated by stir-fries & curries. My favourite stir fries are Pad Grapow (chicken, pork or beef stir fried with very fresh french beans, mushroom, capsicum, chilli & sweet basil—very good presentation & generous servings) and Nir Gratiem (beef with pepper corn, garlic, onion & capsicum). You can request the spiciness of the food accordingly. But don't expect to be too authentic without much chilli!

The curries section is divided into Thai & Burmese. I must admit that I prefer the Burmese curries as they don't contain coconut (I'm not a big fan of coconut cream - and not for health reasons). The Burmese seafood curry is fantastic with a very tasty light curry sauce dominated by onion, garlic, ginger & Burmese spices and generous pieces of prawns, half a crab, mussels, fish, scallops & squids. It tasted better with steamed rice rather than fried rice.

You can also have Burmese lamb curry (Thoe Thar Masala Hin) and a sweet beef curry (Ame Thar A Cho---different from Malaysian 'rendang' or Japanese sweet curry) if you are not into seafood. There are potatoes in these curries but you can request just the meat without the spud!

The Khaw Pad (Thai fried rice) comes with a choice of chicken, pork, beef & prawns and they are tasty on their own or you can have them with other main courses.

Vegetarian selections are plentiful and they are cheaper too. Lots of tofu dishes in the menu to keep the protein intake adequate for those herbivores!

Desserts are better than your average Thai restaurants in Melbourne. My favourite is banana dumpling with coconut ice cream. The dumplings are made of sweet banana wrapped in sticky rice & banana leaves before being steamed - not too sweet with a nice sticky texture. Other desserts include Taro pearls in coconut cream and black bean & sago in coconut syrup.

The wine list is limited to a couple of small pages but there are a few reasonable choices . We had the Pepperjack shiraz ($31) and Cape Schanck Pinot Noir ($23.50) as well as the Matua Hawkes Bay sauvignon blanc (NZ, $25.50)---all are good drops to accompany your meals. There are a few Thai beers (Chang & Singha) as well as local selections. Corkage is $3.00 per bottle.

The last time we were at the restaurant, there were at least 30 orders of take-aways. Bookings are definitely essential if you don't want to be disappointed!! Try it & give me feedback!!

Price guide:

Tom yum goong (prawns) soup ($10.90)
Larb Nir (beef rump salad) ($16.90)
Pad grapow stir fries ($17.90)
Burmese seafood curry ($21)
Khaw Pad (fried rice) ($13.90)
Banana dumpling with coconut ice cream ($8)

Seating: 58 (adequate spaces between tables and comfortable chairs)

Access: 2 small steps at the entrance (may need assistance for wheelchair)

***Specials: Buy one main get one free (on Mondays except on the first Monday of the month where you can have* All-you-can-eat for $20)**

Opening hours: 7 days (5.30pm till 10.00pm) . Bookings essential on weekends & Mondays.

Parking : Rows of free parking spaces in front of the restaurant

SIMPLY CHINESE

Siew Khin (Happy) Tang

In this addition of Qi 2006, I have been influenced somewhat by current affairs that attempt to bridge the diverse cultures and languages that exist in Australia. Each of us have often yearned to master a language or dialect other than our own.

This issue has prompted me to introduce phrases which may be useful to our many readers and colleagues in their daily encounters or travels. As an initial introduction, I have chosen sixteen of the most commonly used phrases.

English	Pin Yin	Chinese Charactors
Hello / Hi	ni hao	你好
Good morning	zao shang hao	早上好
Good evening	wan shang hao	晚上好
Good night	wan an	晚安
Goodbye	zai jian	再見
Thank you	xie xie	謝謝
Sorry	dui bu qi	對不起
How are you?	ni hao ma?	你好嗎?
Very well	hen hao	我很好
I (don't) understand	wo (bu) ming bai	我(不)明白
What's your name, please?	qing wen ni de ming zi?	請問你的名字?
My name is ...	wo de ming zi shi ...	我的名字是 ...
Can I help?	wo ke yi bang mang ma?	我可以幫忙嗎?
Yes / No (Correct / Incorrect)	shi / bu shi (dui / bu dui)	是 / 不是 (對 / 不對)
Please come in	qing jin	請進
Please sit	qing zuo	請坐

God Created Man

God created the donkey
and said to him.
"You will be a donkey. You will work un-tiringly
from sunrise to sunset carrying burdens on your back.
You will eat grass, you will have no intelligence and
you will live 50 years."
The donkey answered:
"I will be a donkey, but to live 50 years is too much,
give me only 20 years"
God granted his wish.

God created the dog
and said to him:
"You will guard the house of man.
You will be his best Friend.
You will eat the scraps that he gives you
and you will live 30 years.
You will be a dog."
The dog answered:
"Sir, to live 30 years is too much,
give me only 15 years."
God granted his wish.

God created the monkey
and said to him:
"You will be a monkey.
You will swing from branch to branch doing tricks.
You will be amusing and you will live 20years."
The monkey answered:
"To live 20 years is too much,
give me only 10 years."
God granted his wish.

Finally God created man...
and said to him:
"You will be man, the only rational creature
on the face of the earth.
You will use your intelligence to become master
over all the animals.
You will dominate the world and you will live 20years."

Man responded:
"Sir, I will be a man but to live only 20 years is very little,
give me the 30 years that the donkey refused,
the 15 years that the dog did not want and
the 10 years the monkey refused."
God granted man's wish.

And since then, man lives 20 years as a man,
marries and spends 30 years like a donkey,
working and carrying all the
burdens on his back.

Then when his children are grown, he lives 15 years like a
dog taking care of the house
and eating whatever is given to him,

so that when he is old,
he can retire and live 10 years like a monkey,
going from house to house and
from one son or daughter to another doing tricks
to amuse his grandchildren.

That's Life.....

Does your dog bite..hope not!

Hercules was recently awarded the honorable distinction of Worlds Biggest Dog by Guinness World Records. Hercules is an English Mastiff and has a 38 inch neck and weighs 282 pounds.

With "paws the size of softballs" (reports the Boston Herald), the three-year-old monster is far larger and heavier than his breed's standard 200lb. limit.

Hercules owner Mr. Flynn says that Hercules weight is natural and not induced by a bizarre diet: "I fed him normal food and he just grew"

Check out his picture !!!

Australian Chinese Medical Association (Vic.) Inc.

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Australian Chinese Medical Association of Victoria

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Tel: 9899 6380 *Fax*: 9899 6389 *Email*: office@acmav.org

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1st January 2007 to 31st December 2007

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Home Address:

Office Address:

Phone: home _____ office _____ mobile _____

Qualifications: _____ University: _____ Year: _____

Academic position (Hospital, University, etc.): _____

Type of practice: ☐ GP ☐ Specialist ☐ Hospital ☐ Other _____

Specialty: _____ Special Interests: _____

Partner's Name: _____ Chinese Dialects Spoken: _____

I agree to abide by the rules and regulations of the **Australian Chinese Medical Association (Vic) Inc.**

Signature: _____ **Date**: ___ / ___ / _____

Entrance Fee (new members only)	**$50**
Annual Subscription Fee	
Ordinary member	**$160***
Medical Student	**$50**
1st or 2nd year HMO	**$90**
Affiliate member** (non-medical partner)	**$100**

10% GST APPLIES TO ALL FEES

* New members (Ordinary Members only) are entitled to pro rata fees of $120, $80 & $40 depending on the month joined

** co-payment for meals required

FOR NEW MEMBERS ONLY

Proposer 1 Name: _____

Signature: _____

Proposer 2 Name: _____

Signature: _____

☐ ***New Member*** ☐ ***Renewal of Membership***

Please find enclosed my cheque ***OR*** credit card details payable to **Australian Chinese Medical Association Victoria Inc.**, for the following:

Entrance fee $ _____

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Notes:

Notes:

Contributor's List

1.	Ann BROTHERS	Curator, Medical Histrory Museum, Vic
2.	Andrew BUI	Colorectal Surgeon, Vic
3.	Lean-Peng CHEAH	Lecturer in Surgery, Surgeon, The University of Melbourne, Vic
4.	Min Li CHONG	General Practitioner, West Heidelberg, Victoria
5.	Anne E DUGGAN	Director of Gastroenterology, John Hunter Hospital, Newcastle, NSW.
6.	Clive FRASER	"Doctor Cam Shaft", Psychiatrist, QLD
7.	Robert GAN	Dental Surgeon, Royal Dental Hospital, Vic
8.	Mukesh HAIKERWAL	President, The Federal AMA 2006
9.	Boon Hung HONG	Surgeon, Vic
10.	David de KRETSER, AC,	Governor of Victoria
11.	Que LAM	Chemical Pathologist, Symbion Health, Vic
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18.	Caroline REED	Microbiologist, Symbion Health, Vic
19.	Stuart ROBERTS	Gastroenterologist, Alfred Hospital, Vic
20.	Ferry RUSLI	Gastroenterologist, Vic.
21.	Valerie SURTEES	Cytopathologist, Symbion Health, Vic
22.	Matthew TALLACK	Scientist, Symbion Health, Vic
23.	Eng-Seong TAN	Consultant Psychiatrist, St. Vincent's Hospital; Lecturer, Melb. University, Vic
24.	Siew-Khin (Happy) TANG	Pathologist, Symbion Health, Vic
25.	Frank TEOH	Psychiatrist(retired), Vic
26	Martin B Van Der WEYDEN	Editor, The Medical Journal of Australia
27.	Gillian WOOD	Microbiologist, Symbion Health, Vic
28.	Christopher WORSNOP	Respiratory and Sleep Physician, Alfred Hospital, Vic
29.	Jun YANG	Endocrinology Registrar, Monash Medical Centre, Victoria

Advertisers' Index

Acknowledgements

As the years go by, each of us seem to have more commitments with more tasks to perform. I am grateful to our contributors of articles, for sharing their medical knowledge and experience in their specialised fields.

To friends who have shared their travel experiences and culinary expertise, we thank you for stimulating our senses with
hope that we may enjoy such delights in the future.

To our sponsors who continually lend their support, I thank you for your contribution, grateful that in the present climate of financial constraints you have once again shown your generosity.

As in previous publications, articles from MJA editorials (from Editor's desk) have given us insight to matters of interest to the medical profession, and stimulated lively discussion amongst our members. I thank Professor Martin Van Der Weyden
for permission to publish them.

To members of the ACMAV and the Committee, I thank you for your patience in the publication of this issue. Although I will not be persuaded to edit the next issue, I urge other younger members of the association to accept the position which I found most mentally rewarding and stimulating.

I thank my co-editor Adrian Mar for his time and most appreciated views in preperation of this publication, and to Eng-Seong Tan for his advice and help in initiating the new segment on "Simply Chinese", which I hope will delight and stimulate our friends and colleagues of diverse origins in increasing their vocabulary of Mandarin .

To Belinda Chen of Ivy Printing, who has again been so patient and diligent in scouting for an appropriate illustration for the cover picture.

I thank you all !

Siew-Khin Tang
Editor