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The bird has for centuries fascinated mankind for its ability to fly, as if serving as a messenger between earth and heaven. The phoenix was a royal emblem during the Shang and Zhou Dynasty. The Eagle is used by many countries as a national logo! Some birds possess amazing athletic abilities. For instance, the peregrine falcon can fly at a speed up to 270 miles/hour while swooping down on its prey.

The bird shown here is the Lilac Breasted Roller (Caracas Caudatus) which is the national bird of Botswana, although it is found in many African countries like Tanzania, Zambia, etc.

Despite its small size, weighing no more than 4 oz, this roller is considered one of the most beautiful birds in the world, owing to its pastel plumage, striking marks and long tail streamers. This bird is strikingly colourful with a total of 10 colours.

A tiny bird like this roller perching on a tree branch is not difficult to capture in a photo, but to ‘freeze’ it in flight showing its intricately colourful ventral side and fully spread wings requires the right moment, patience, quite a bit of luck, and of course, the right kind of camera and telephoto lens. To have the opportunity to see and to take photos of such wildlife in their natural habitat is the reason why many people are so fond of making trips to Africa, over and over again!
Out of Your Comfort Zone in Sports Medicine: The Facts & Fictions

Prof Patrick Shu-hang YUNG

Chairman, Department of Orthopaedics & Traumatology, Faculty of Medicine, CUHK
President, Hong Kong Association of Sports Medicine & Sports Science (HKASMS)
President, Asian Federation of Sports Medicine (AFSM)

WHAT IS SPORTS MEDICINE?

Sports Medicine is a subspecialty in medicine that deals with exercise & physical fitness, as well as treatment and prevention of injuries related to exercise and sports participation. The scope of service already highlights the characteristics of Sports Medicine, which is indeed involving skills and knowledge from multidiscipline to work for the best benefit of human beings in sports participation, and not just limited to dealing with sports injuries.

In some developed countries, Sports Medicine is a recognised medical specialty (with similar training and standards to other medical specialties), whereas, in many other countries/regions, including Hong Kong, it is a special interest area but not an actual specialty. It can broadly also refer to doctors and many other paramedical practitioners who very often work together as a team to ensure the best fitness, performance prevention, treatment & recovery for those who participate in sports and exercise. Very often, for a well-established Sports Medicine team, members should include Sports Physicians, Orthopedic Surgeons, Certified Sports/Athletic Trainers, Sports Physiotherapists, Sports Scientist (e.g. Sports Dietitians, Psychologist, Physiologist, Bio-mechanists…...). Usually, the medical doctor is the leader and chief coordinator to lead the team to excel for the athletes and patients.

DEVELOPMENT OF SPORTS MEDICINE IN HONG KONG & AROUND THE WORLD

Sports Medicine societies were first established in Switzerland (1922) followed by Germany (1924), France (1929) and Italy (1929). Hong Kong, it is a special interest area but not an actual specialty. It can broadly also refer to doctors and many other paramedical practitioners who very often work together as a team to ensure the best fitness, performance prevention, treatment & recovery for those who participate in sports and exercise. Very often, for a well-established Sports Medicine team, members should include Sports Physicians, Orthopedic Surgeons, Certified Sports/Athletic Trainers, Sports Physiotherapists, Sports Scientist (e.g. Sports Dietitians, Psychologist, Physiologist, Bio-mechanists…...). Usually, the medical doctor is the leader and chief coordinator to lead the team to excel for the athletes and patients.
specific European countries. It is a goal of the European Federation of Sports Medicine Associations (EFSMA) to eventually establish Sports Medicine as a specialty in all European countries. For example, European templates for Sports Medicine specialisation generally involve four years of specialist training, including internal medicine, with special emphasis on Cardiology, Emergency medicine and clinical nutrition, Orthopedics and Traumatology, as well as Physical and Rehabilitation medicine. Fellowship programmes were implemented all over Europe in recognised Sports Medicine centres for training. Similarly, in Australia and New Zealand, Sport and Exercise Medicine is a standalone medical specialty, with the Australasian College of Sport and Exercise Physicians being one of Australia’s 15 recognised medical specialty Colleges.

However, not necessarily all the developed countries offer a recognised Sports Medicine Specialty. Such recognition has not yet occurred in some of the countries with very strong pedigrees in academic publication in the Sports Medicine field, including the U.K., Sweden, Norway, Singapore, South Africa and the U.S.A.1,2 Individual’s Medicine indeed is only a subspecialty field rather than a standalone specialty in the U.S.A. and Canada, very much similar to Hong Kong. Taiwan, Singapore, Thailand, India and Iran have been working on the development of a distinct Sports Medicine specialty for years, but until now, there is no country in Asia with well established and standalone medical specialty in Sports Medicine, which largely functions as a subspecialty field. There are quite a number of Asian countries/cities (India, Taipei, Singapore, Tehran...) providing different postgraduate education programmes for the training of Sports Medicine practitioners, including the Master of Science programme in Sports Medicine & Health Science run by The Chinese University of Hong Kong (CUHK) since 2004. The CUHK programme is one of the oldest and most reputable post-graduate programmes in the world, having already nurtured over 800 graduates.

WALKING OUT OF THE COMFORT ZONE FOR MODERN DAY SPORTS MEDICINE DOCTORS!

As already pointed out earlier, in Hong Kong right now, Sports Medicine is not a medical specialty, but a special interest area with doctors mainly coming from Orthopaedics, Cardiology, Emergency medicine, family doctors or other specialties, along with a sizeable group of physiotherapists regularly contributing to this field. The majority of this group of experts have had in-depth training and knowledge acquisition in Musculoskeletal medicine, particularly in the treatment, rehabilitation, and prevention of sports injuries; they regularly take care of sports injuries of individual players or teams. Some other experts, a relative minority, are dealing with musculoskeletal injuries involving common areas such as the knee, ankle, and shoulder. However, along the rapid development of "fashions" of different kinds of new sports activities in Hong Kong in recent years, there are more and more sports injuries involving those "No man’s land" areas, such as the fingers, wrists, elbows, feet and toes. The increasing incidents of this new group of injuries have required our Sports Medicine practitioners to be equipped with the appropriate knowledge and skills to handle and to provide the best optimal and appropriate care. There is also an increasing trend in application of alternative therapies or application of biologics in tackling sports injuries; in particular, the different types of injection therapies have become one of the hottest topics in Sports Medicine in recent years. I do believe that there is a need to explore new science for tackling some difficult sports injuries. Nevertheless, we definitely need to understand and to be able to differentiate all the "Facts" from the "Fictions", demanding vigorous backing up with scientific evidence and evidence-based medicine, whenever we consider new treatment regimes.

In addition to managing sports injuries, modern-day Sports Medicine doctors should also work to improve the performance of the athlete, as well as ensuring their safety while performing the sports activity. The latter work includes assessment of medical fitness before participating in sports, injury risk assessment, implementation of sports-specific injury prevention programmes, as well as taking their practice from the consultation room on to the sports field. Moreover, Sports Medicine doctors should also very often promote the benefits of regular physical activities by delivering concepts of “Exercise is Medicine” and physical activities interventions, including a healthy life style and diet, to prevent chronic illness such as hypertension & diabetes, minimising the burden of disease directly attributable to physical inactivity.

FUTURE DEVELOPMENT OF SPORTS MEDICINE IN HONG KONG

Sports Medicine, in itself as a specialty in medicine, is yet to be realised in Hong Kong. We have good models from other countries, particularly from Europe, to learn and take reference from. But to be able to do so in Hong Kong in response to to the increasing demands and needs, relevant training, accreditation, career prospect and most importantly, government policies are all very important elements to be established or enhanced. To prepare for the upcoming challenges and opportunities, Sports Medicine doctors in the modern era should also be multi-talented and prepared to walk out of their current comfort zone with focus mainly on taking care of sports injuries. They should ideally be all rounded, with comprehensive skills and knowledge in Sports Medicine and having very good communication skills. To steer the Sports Medicine team, they should also be well connected to others including doctors of other specialties, physiotherapists, sports dietitians and psychologists, and other sports scientists, so as to work out the best advice for their clients, inclusive of both professional sportsmen and amateur folks who are participating in sports just for wellness.

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Why is My Wrist Painful after Sports?

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INTRODUCTION & EPIDEMIOLOGY

The wrist is a complex joint. It consists of 15 pieces of bone, more than 25 articulations, and more than 40 named ligaments. There are 24 tendons, two major blood vessels, two major nerves and numerous cutaneous nerves crossing and sophisticatedly constituting the wrist. Injury to any of the above structures commonly happens in sports.

There are no epidemiological data on sports injuries related only to the wrist region. Previous studies revealed that approximately 25% of all sports-related injuries involve the hand and wrist. The present incidence should be higher as a result of the increased activity level of the general population, and as wrist injuries are better understood and identified in recent years. Among all the sports-related wrist injuries, distal radius fracture is the most easily recognised disease. It accounts for 23% and 17% of all sports-related fractures in adolescents and adults, respectively. Fall on an outstretched hand or high energy collisions in any sport explains the fractures. They are common with badminton, basketball, gymnastics and ice-skating, while soccer contributes to 20% to 50% of distal radius fractures sustained during the sport. In Hong Kong, soccer has made up the majority of emergency attendance with sports injury. Distal radius fracture produces acute pain, swelling, bruising and even deformity, which prompts the sports players to seek medical attention immediately. X-ray appearance is usually obvious. A delay in treatment from missed diagnosis is therefore rare.

However, many players are annoyed by various kinds of wrist pain for which the diagnosis is not as obvious. Many wrist problems are initially disregarded and result in a delay in treatment with consequential impacts and complications. Although the epidemiology of sports-related wrist injuries is lacking, the high prevalence rate of up to 73% for wrist pain and 28% for overuse wrist injury, and the incidence rate of up to 9% for wrist pain and 26% for overuse wrist injury in young athletes shown in a systemic review published in 2015 signify that wrist problem in sports should be a notable issue for the whole population.

CAUSES OF WRIST PAIN AFTER SPORTS

Causes of wrist pain after sports are numerous, as shown in Table 1. Wrist pain that has happened after sports could have resulted from (1) a direct impact during an acute injury, e.g. fall, collision, sudden forceful twisting/rotation/extension/flexion/radial deviation/ulnar deviation, or from (2) an overuse injury, e.g. repetitive wrist loading in different directions. The following is an overview of the common causes of wrist pain (besides distal radius fracture) sustained in sports.

RADIAL WRIST PAIN

A. Scaphoid Fracture

Scaphoid fracture is the commonest carpal fracture, accounts for 60 - 90% of all carpal fractures. It has been estimated that nearly 1% of college football players will sustain a scaphoid fracture per year. Falling onto an outstretched hand, usually with the wrist in extension and radial deviation such that the scaphoid becomes more prominent and hits onto the floor, would result in a fracture. A direct blow to the wrist, such as being hit by a baseball, can also fracture the scaphoid.

Approximately 75% of the surface of the scaphoid is covered with cartilage. The proximal pole vascularity are supplied from branches of the radial artery entering through the distal dorsal ridge. The large volume of bone dependent on a single intra-osseous vessel poses a high risk of avascular necrosis and fracture nonunion. Since the vascularity of the scaphoid is tenuous, bruising and pain after the fracture may not be obvious enough to prompt the players to seek care. It is not uncommon to find a scaphoid fracture developed into nonunion with a remote history of a wrist sprain. An acute scaphoid fracture is sometimes not easily visualised on X-rays because of its peculiarly twisted peanut-like shape. Missing a diagnosis poses a devastating injury to athletes and even ends the sports career for the combat sports players.

Exquisite tenderness in the anatomical snuffbox or in axial loading of the thumb should raise the suspicion of a scaphoid fracture. X-rays of the wrist include
<table>
<thead>
<tr>
<th>REGION OF WRIST PAIN</th>
<th>Structure</th>
<th>Type of Injury</th>
<th>Examples of Related Sports</th>
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<td>Distal radius fracture</td>
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<tr>
<td></td>
<td>Bone</td>
<td>Scaphoid fracture</td>
<td>- Sports requiring overhead movements</td>
</tr>
<tr>
<td></td>
<td>Metacarpal base fracture/Subluxation</td>
<td>- Sports requiring overhead movements</td>
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<td></td>
<td>Bennett’s fracture, Rolando fracture</td>
<td>- Fall/Direct collision/Axial loading in any sports - Combat sports - Handlebar injury</td>
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</tr>
<tr>
<td></td>
<td>Trapezium fracture, Trapezoid fracture</td>
<td>- Sports requiring overhead movements</td>
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<td></td>
<td>Joint/ Ligament</td>
<td>Radiocarpal ligament tear (usually with ganglia at the volar radial wrist)</td>
<td>- Gymnastics, Yoga, Pilates</td>
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<td></td>
<td>Tendon</td>
<td>DeQuervain’s disease</td>
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<td></td>
<td>Tendon</td>
<td>Intersection syndrome (Oarsman’s wrist)</td>
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<td></td>
<td>Tendon</td>
<td>Flexor Carpi radialis tendonitis</td>
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<td></td>
<td>Nerve</td>
<td>Wartenberg’s syndrome</td>
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<td><strong>ULNAR</strong></td>
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<td>Triquetral fracture</td>
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<td>Ulnar styloid fracture</td>
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<td></td>
<td>Hook of hamate fracture</td>
<td>- Fall in any sports, in-line skating, Racket sports, Volleyball</td>
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<tr>
<td></td>
<td>Pisiform fracture</td>
<td>- Golf, Squash, Gymnastics, Under-water rugby, other racket sports</td>
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<tr>
<td></td>
<td>Ligament</td>
<td>TFCC (Triangular Fibrocartilage Complex)</td>
<td>- Racket sports, Golf, Baseball, Gymnastics, Yoga, Karate, Kendo, Kickboxing, Martial arts and other combat sports</td>
</tr>
<tr>
<td></td>
<td>Joint</td>
<td>Lunotriquetral instability</td>
<td>- Fall in any sports</td>
</tr>
<tr>
<td></td>
<td>Ligament</td>
<td>TFCC (Triangular Fibrocartilage Complex)</td>
<td>- Racket sports, Golf, Baseball, Gymnastics, Yoga, Karate, Kendo, Kickboxing, Martial arts and other combat sports</td>
</tr>
<tr>
<td></td>
<td>Tendon</td>
<td>ECU (extensor carpi ulnaris) tendonitis</td>
<td>- Tennis, Golf, Rugby, Hockey</td>
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<td></td>
<td>Tendon</td>
<td>FCU (flexor carpi ulnaris) tendonitis</td>
<td>- Rugby, Squash, Badminton, Golf</td>
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<td></td>
<td>Nerve</td>
<td>Guyon’s canal syndrome</td>
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<td></td>
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<td>Hypothenar hammer syndrome</td>
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<tr>
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<td>Bone</td>
<td>Capitate fracture</td>
<td>- Fall in any sports</td>
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<td></td>
<td>Lunate fracture</td>
<td>- Gymnastics, Handball, American football, Push-ups</td>
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<tr>
<td></td>
<td>Kienbock’s disease</td>
<td>- Fall in any sports, American Football, Rugby, Kickboxing, Karate, other combat sports</td>
<td></td>
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<tr>
<td></td>
<td>Ligament</td>
<td>Scapholunate dissociation</td>
<td>- Weight lifting, Gymnastics, Yoga, Pilates, Push-ups</td>
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<tr>
<td></td>
<td>DCSS (dorsal capsule scapholunate septum) injury</td>
<td>- Weight lifting, Gymnastics, Yoga, Pilates, Push-ups</td>
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<tr>
<td></td>
<td>Nerve</td>
<td>Carpal tunnel syndrome</td>
<td>- Cycling, Weight lifting, Hockey, Rock-climbing, Rowing, Swimming, Wheelchair athletics</td>
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<tr>
<td></td>
<td>Nerve</td>
<td>Distal posterior interosseous nerve impingement syndrome</td>
<td>- Gymnastics, Weight lifting, American football, Yoga</td>
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The following are the most clinically relevant adverse reactions: 1) Cardiac toxicity, 2) Hemorrhage, and 3) Fatigue. Adverse reactions are dose-related, and patients should be monitored for signs of cardiac toxicity, hemorrhage, and fatigue. Cardiac toxicity may include pericardial effusion, pericarditis, myocardial infarction, myocardial ischemia, congestive heart failure, atrial fibrillation, atrial tachycardia, atrial flutter, atrial premature contractions, and atrial flutter. Adverse reactions that may be dose-related include hypertension, hypotension, and peripheral edema. Hemorrhage may include gastrointestinal bleeding, hemoptysis, and hematuria. Fatigue may be severe and may include symptoms such as fatigue, weakness, and asthenia.

REFERENCES
posteroanterior (PA), lateral, scaphoid long profile views, semi-supination and semi-pronation views. A high-resolution CT scan should be arranged for fracture identification or alignment in suspicious cases where fracture cannot be visualised on X-rays. MRI may be needed sometimes to confirm an occult fracture.

B. Radial Sided Tendinopathies

1. DeQuervain’s Disease
It is the commonest wrist tendinopathy in sports. Repetitive thumb extension and abduction, or repeating gripping, grasping, pinching or wring actions irritate the sheath (first extensor compartment retinaculum) around the two tendons (abductor pollicis longus (APL) and extensor pollicis brevis (EPB)), causing thickening and swelling that restricts their motion. Swelling and tenderness localised at the first extensor compartment (Fig. 1), limited thumb abduction and extension action, pain at resisted thumb abduction, marked pain when the wrist is bent ulnar-wards while the player is grabbing the thumb within a fist (modified Eichoff’s test) (Fig. 1), and pain when the thumb is grasped and being pulled ulnar-wards (Finkelstein’s test) make the diagnosis.

2. Intersection Syndrome (Oarsman’s Wrist)
It is tenosynovitis at the crossing point between the first (APL and EPB) and second (extensor carpi radialis longus and brevis) extensor compartment tendons, resulted from repetitive resisted wrist extension. Players typically experience tenderness at around 4 - 8 cm proximal to the Lister’s tubercle (Fig. 2) and pain at resisted wrist extension and radial deviation. MRI of the wrist and distal forearm is useful to confirm the diagnosis.

3. Flexor Carpi Radialis (FCR) Tendonitis
FCR travels from the medial elbow across the radial wrist through a fibro-osseous tunnel adjacent to the trapezium towards its insertion on the second metacarpal. This deviated course predisposes the tendon to irritation by repetitive wrist flexion or acute over-stretching. Radial wrist pain courses from the radial palmar wrist crease towards the base of the second metacarpal, and is aggravated on resisted wrist flexion and radial deviation.

ULNAR WRIST PAIN

A. Triquetral Fracture
Fracture of the dorsal cortex of triquetrum is the second most common carpal fracture resulting from impaction, avulsion or shear force. A fall with the wrist extended and ulnar deviated, causing impaction of the ulnar styloid on the dorsum of the triquetrum, is the commonest mechanism. There is swelling and pain at the dorsal ulnar wrist. Tenderness is localised on the dorsum of triquetrum (Fig. 3). Because of overlapping carpal bone shadows, this fracture may be missed on a PA or lateral X-ray. A semi-pronation view makes the fracture fragment more apparent.

B. TFCC (Triangular Fibrocartilage Complex) Tear
TFCC is a ligament-fibrocartilage complex that consists of the triangular fibrocartilage, surrounding ligamentous tissues, including the radioulnar ligament, and the sheath floor of the extensor carpi ulnaris (ECU) (Fig. 4). It stabilises the ulnocarpal and distal radioulnar joints (DRUJ), distributes load between the ulna and
ulnar carpus and introduces smooth forearm rotation. TFCC is torn following a fall or excessive loading onto the pronated hyperextended wrist, hyper-rotational injuries to the forearm, or repetitive forceful forearm rotation and wrist ulnar deviation. Players experience ulnar wrist pain with forearm rotation, gripping, wrist ulnar deviation, and feeling slacking at the ulnar wrist in carrying heavyweights, twisting doorknob or wringing towel. There is tenderness at the volar base of the ulnar styloid (foveal sign), pain on passive forearm rotation and ulnocarpal grinding, and DRUJ laxity in the ballottement test. Gradient echo sequence T2-weighted image and fat suppression T1-weighted MRI images help delineating detailed TFCC structure and the tear.

C. ECU Tendonitis and Instability

ECU travels from the lateral elbow across the ulnar wrist through a fibro-osseous tunnel embraced by the ECU subsheath for about 1.5 cm within the ECU groove (Fig. 4), and attaches on the dorsal aspect of the base of the fifth metacarpal. With the wrist in supination, the tendon exits the subsheath at around 30°. Increased ulnar-negative variance (ulna is shorter than the radius at the level of the articular surface), and shallower and shorter ECU groove have been shown to be associated with ECU pathologies. With hyper-supination, ulnar deviation and wrist flexion forces, the tension on the ECU and subsheath is greatest, which leads to ECU tendonitis, subluxation, dislocation and even traumatic or attritional rupture. Athletes involved in racket or stick-handling sports are often affected, and ECU injuries accounted for 76% of wrist injuries in male tennis players.17 They experience pain and sometimes snapping over the course of the ECU tendon at forceful gripping, supination, wrist flexion/extension, or ulnar deviation, such as the non-dominant hand in double-handed backhand in tennis, or leading hand in the downward phase of a golf stroke. There are tenderness and swelling along the ECU tendon, pain with resisted wrist extension and ulnar deviation, and weakness of ECU action. ECU tendon subluxation or dislocation may be found with wrist extension, ulnar deviation and supination. ECU synergy test (Fig. 5) is positive - painful in the resisted thumb and middle finger abduction with the forearm in full supination. Ultrasound gives a dynamic evaluation to compare the stability of ECU with the contralateral side. MRI is sensitive to identify ECU pathologies.

C. ECU Tendonitis and Instability

Fig. 4. Anatomy of TFCC and ECU (Photo from personal collection)

CENTRAL WRIST PAIN

A. Scapholunate Ligament (SLL) & Dorsal Capsulo-Scapholunate Septum (DCSS) Injury

SLL is the most important ligament maintaining the strength and stability of the wrist. The dorsal part of the SLL is the most important part for the stability of the scapholunate joint. Its insertion into the dorsal capsule and dorsal intercarpal ligament creates the DCSS (Fig. 6). DCSS injury represents the earliest (pre-dynamic) stage of the scapholunate instability and usually arises from a sudden or repetitive wrist hyperextension or hyper-flexion loading force. It is common to encounter players complaining of dorsal central wrist pain during push-ups and power grips without X-ray or MRI evidence. It is sometimes misdiagnosed for a long time.

Complete SLL tear creates scapholunate widening when stress is applied (dynamic stage). Additional injury to the surrounding secondary stabilisers results in static widening of the scapholunate joint (static stage). SLL tear is the commonest cause of carpal instability and most commonly following a fall onto an extended, ulnar deviated wrist. Contact or combat sports which place the athlete in a position of impact with hyperextension, ulnar deviation and supination of the wrist can also lead to SLL tear.

Fig. 6. Diagram of a transverse section showing DCSS (Photo from personal collection)
Players experience pain, and mild swelling over the dorsal central wrist aggravated by heavy use, weak grip strength, and sometimes reduced mobility. Tenderness is easily found distal to the Lister’s tubercle with the wrist at mild flexion. Pain is elicited at extreme passive wrist flexion or extension. Watson’s test is positive in SLL complete tear. It is performed with the examiner’s thumb pressed onto the scaphoid tuberosity to prevent the scaphoid from flexing while the wrist is moved passively from ulnar to radial deviation. Dorsoradial wrist pain is induced as the proximal pole of the scaphoid is subluxed dorsally. Clunking is produced when the thumb pressure is released. Standard X-rays may appear normal, only showing increased flexion of the scaphoid. Anteroposterior clenched fist view may show scapholunate widening. MRI is helpful, and arthroscopy is the gold standard in the diagnosis.

CONCLUSION

Sports injuries in the wrist can be a complex issue. Good knowledge of these entities minimises the incidence of missing a diagnosis and delaying proper treatment, and helps the players to prevent further damage while returning to sports in a smart manner.

References


Dermatology Quiz

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MBBS(HK), FRCP(Lond, Glasg, Edin), Dip Derm(Glasg), FHKCP, FHKAM(Medicine)
Specialist in Dermatology and Venerology

What is the diagnosis of her skin lesion?
What investigations are you going to order?
How do you treat this patient?

(See P.32 for answers)
# Certificate Course on 
**Respiratory Medicine 2021**
*(Video Lectures)*

**Objectives:**
To enhance understanding and provide recent updates in various aspects of Respiratory medicine.

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<td>6 Oct 2021</td>
<td>Indication, monitoring and troubleshooting for CPAP therapy</td>
<td>Ms. Maggie Lit</td>
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<td>KCC NC(Respiratory)/OEH NC(Respiratory)</td>
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**Date:** 1, 8, 15, 29 September & 6 October 2021 (Wednesday, skip 22 September, public holiday)

**Time:** 7:00 p.m. – 9:00 p.m. (2 hours per session)

**Course Feature:** Video lectures (with Q&A platform for participants to post the questions)

**Quiz for doctors:** To tie in with the CME requirements for video lectures, DOCTORS are required to complete a quiz after the completion of each lecture.

**Language Media:** Cantonese (Supplemented with English)

**Course Fee:** HK$1,200 (5 sessions)

**Certificate:** Awarded to participants with a minimum attendance of 70%

**Deadline:** 24 August 2021

**Enquiry:** The Secretariat of The Federation of Medical Societies of Hong Kong
Tel.: 2527 8898  Fax: 2865 0345  Email: vienna.lam@fmshk.org

CME / CNE / CPD Accreditation in application

Online Application from website: http://www.fmshk.org
MCHK CME Programme Self-assessment Questions

Please read the article entitled “Why is My Wrist Painful after Sports?” by Dr Clara Wing-yee WONG and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 July 2021. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. Distal ulnar fracture is the most easily recognised condition among all sports-related wrist injuries.
2. If a complete scaphoid fracture was initially not noticed five weeks ago, it could usually heal easily with subsequent casting for four weeks.
3. Scaphoid fracture is a rare carpal fracture its diagnosis is easily recognised at presentation.
4. In some cases, CT scan or MRI should be arranged for particular fracture identification or alignment in suspicious cases where fracture cannot be visualised in X-rays.
5. DeQuervain’s disease is the commonest wrist tendinopathy in sports.
6. DeQuervain’s disease, Intersection syndrome and triquetral fracture can cause radial wrist pain.
7. MRI of the wrist and distal forearm is not useful to confirm the diagnosis of Intersection syndrome.
8. If a patient has ulnar wrist pain with wrist ulnar deviation and forearm supination, TFCC (triangular fibrocartilage complex) injury or ECU (extensor carpi ulnaris) tendon problem can be the diagnosis.
9. In triquetral fracture, tenderness is localised on the dorsum of triquetrum.
10. TFCC (triangular fibrocartilage complex) stabilises the ulnocarpal and distal radioulnar joints (DRUJ), distributes load between the ulna and ulnar carpus, and introduces smooth forearm rotation.

ANSWER SHEET FOR JULY 2021

Please return the completed answer sheet to the Federation Secretariat on or before 31 July 2021 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Why is My Wrist Painful after Sports?

Dr Clara Wing-yee WONG
MB ChB(CUHK), MRCSEd, FRCS(Orth), FHKCOS, FHKAM(Orthopaedic Surgery)
Consultant Orthopaedic Surgeon, CUHK Medical Centre
Clinical Professional Consultant, Department of Orthopaedics and Traumatology, Faculty of Medicine, The Chinese University of Hong Kong
Associate Professor of Practice, Department of Orthopaedics and Traumatology, Faculty of Medicine, The Chinese University of Hong Kong
Commission Member, Hong Kong Association of Sports Medicine and Sports Science

1  2  3  4  5  6  7  8  9  10

Name (block letters):____________________________ HKMA No.: ________________ CDSHK No.: ________________
HKID No.: __ __ - __ __ __ __ X X (X) HKDU No.: ________________ HKAM No.: ________________
Contact Tel No.:____________________________ MCHK No. / DCHK No.: __________________(must fill in)

Answers to June 2021 Issue

The Use of Integrative Medicine for Treatment of COVID-19

INTRODUCTION

Dance involves graceful artistry coupled with powerful physicality. In fact, “Dance” has been rated as the most physically demanding job by the Occupational Information Network. Dance-related injuries are quite prevalent, with the foot and ankle region being the most common, followed by knee and spine problems.1

ANKLE INSTABILITY

Ankle sprains are definitely one of the most common injuries.2 When we speak of ankle sprains, we refer to an injury to the lateral ankle ligament complex most of the time. This complex consists of the anterior talofibular ligament, calcaneal-fibular ligament and the posterior talofibular ligament. They act as static stabilisers of the ankle joint and are important for daily and recreational activities. Around 30% of patients suffering from an ankle sprain will develop chronic ankle instability with symptoms of recurrent sprains, impingement and pain. Contrary to the hips and knees, the ankle is relatively resistant to primary osteoarthritis, and evidence suggests that ankle osteoarthritis may be a late-stage sequela of maltreated ankle instability.3,4 Secondary arthritis, especially post-traumatic arthritis, makes up 70 - 80% of all ankle arthritis, with inflammatory arthritis making up most of the remaining cases.5 Clinically, we can perform stress tests on physical examination or x-ray/ultrasound to make a diagnosis.6,7 The acronym of PEACE and LOVE can guide the treatment of soft tissue injuries; it stands for protection, elevation, avoidance of NSAIDS, compression, education, loading, optimism, vascularisation and exercise.8 If conservative treatment fails, surgical repair has well documented outcomes.9 This is typically performed in conjunction with an ankle arthroscopy for the management of intra-articular pathologies. Some papers report that even in ankle instability patients already complicated with early osteoarthritis, they would still benefit from ligamentous repair/reconstruction.10 However, when the diseases progress into end-stage arthritis, ankle arthrodesis and total ankle replacement may be the only options.5

TALUS OSTEOCHONDRAL DEFECTS

Talar osteochondral defects can be present, even in the absence of instability. X-rays and MRI are often sufficient, but diagnostic arthroscopy is still the gold standard.11 Treatment starts with physiotherapy and intraarticular injections. Intra-articular steroids, hyaluronic acid and platelet-rich plasma have all been reported with positive outcomes; some trials suggest that platelet-rich plasma is most superior; however, that is still debated.12,13 Chondroplasty surgery with various marrow stimulation techniques such as microfractures/nano-drilling all have encouraging results and are options when conservative treatment fails.14 Biological augmentation during arthroscopy is currently a hotly researched topic with surgeons using platelet-rich plasma, bone marrow aspirate, 3D scaffolds, etc. However, there is hitherto no clear superiority shown.15 Osteochondral grafting is also an option, and studies have shown autograft from the knee vs fresh cadaveric allograft yield comparable results; nonetheless, these procedures are less often performed.16

ANKLE IMPINGEMENT

Impingement of the ankle is another commonly encountered problem; it is categorised into anterior and posterior impingement.17 Anterior ankle impingement happens in end-range dorsiflexion, commonly seen in contemporary styles of dance. Different osseous and soft-tissue structures can be the culprit of this impingement, and arthroscopic debridement with chilectomy are decent measures if physiotherapy is ineffective.18 Posterior ankle impingement typically presents with deep posterior ankle pain, frequently seen in ballet dancers when they go en-pointe. An os trigonum or an elongated posterior talus tubercle (Steida process) can be culprits of the impingement, in addition to soft tissues such as post-traumatic fibrosis. Endoscopic/arthroscopic excision of the impinging structures is an effective solution and yields better outcomes than open surgery.19

ACHILLES TENDINOPATHY

Achilles tendon pathology is another important differential diagnosis of posterior ankle/heel pain.20 It is useful to classify Achilles tendinopathy into insertional or pre-insertional aetiology since the treatment can be significantly different.21 In general, the term tendinopathy is very broad and non-specific; some believe in an element of degeneration in tendinosis while others feel the role of inflammation, such as in tendonitis is more important.22 Prescribing heel lifts have been shown to reduce Achilles strain and are often a simple and effective treatment modality.23 Physiotherapy, specifically eccentric training, has also been shown to improve tendinopathy.24 Injections such as high volume distension therapy and platelet-rich plasma are popular treatments, but the published
papers only show equivocal results.24 A formal surgical debridement is an option that often requires concomitant reattachment of the Achilles using suture anchors. The diseased tendon segment is often quite extensive, and a tendon transfer (e.g. harvesting the flexor hallucis longus) is also frequently necessary. Neglect of Achilles tendinopathy sometimes ends with an acute-on-chronic process. Most patients are usually able to resume dancing recreationally, but it is often a career-ending injury for professional dancers.

METATARSAL STRESS FRACTURE

In dancers presenting with unexplained foot pain, especially if there is a history of recent changes in training regime and rehearsal schedules, always consider the possibility of a stress fracture.26-28 One can imagine that a teenage girl who dances multiple hours in front of a mirror is prone to be very body-conscious and may embark on various dieting regimes. They are at risk of developing the "female athletic triad" of amenorrhea with low energy (with or without an eating disorder) and low bone mineral density, predisposing them to stress fractures. Treatment is activity modification, psychological intervention and the education of a healthy balanced diet; full resumption of dancing can only be expected after 12 weeks.

CONCLUSION

Dance is an art form requiring tremendous physicality; as a result, the injury prevalence is very similar to those in sports. Foot and ankle problems are the predominant pathology, and dancers should be considered with the same scale as athletes; their physical needs are much greater than the average person, and treatment should be tailored to help meet those demands. Dance medicine is still in its infancy, but significant amounts of research have been going into this area within the past decade, allowing us more insight into how to properly help this special group of patients.

References

# Certificate Course on Renal Medicine 2021

## (Video Lectures)

**Jointly organised by**

- The Federation of Medical Societies of Hong Kong
- Hong Kong Society of Nephrology

## Objectives:

To update the participants on new advances in renal medicine and clinical practice of common renal problems, and to help the participants to interpret results of common renal investigations.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topics</th>
<th>Speakers</th>
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</table>
| 2 Sept 2021| Common Investigation Tests for Renal Disease Including Approach to Proteinuria and Haematuria | Dr. Sze-kit YUEN  
Associate Consultant  
Department of Medicine & Geriatrics  
Caritas Medical Centre |
|            | Update and Management of Acute Kidney Injury                           | Dr. Chun-hay TAM  
Clinical Associate Professor (Honorary)  
Department of Medicine & Therapeutics  
The Chinese University of Hong Kong  
Honorary Clinical Assistant Professor  
Department of Medicine, University of Hong Kong |
| 9 Sept 2021| ABC of Hemodialysis Therapy                                            | Dr. Gensy Mei-wa TONG  
Director  
Renal Care  
Hong Kong Baptist Hospital  
Nephrologist-in-charge  
Kai Tak Haemodialysis Center |
|            | Update and Management of Glomerular Disease                            | Dr. Elaine Tsz-ling HO  
Associate Consultant  
Department of Medicine  
Teung Kwun O Hospital |
| 16 Sept 2021| Nutritional Management in Kidney Diseases                              | Ms. Cherry Pui-ying LAW  
Dietitian  
Pamela Youle Nethersole Eastern Hospital |
|            | Kidney Involvement in Multi-System Disorders                           | Dr. Desmond Yat-hin YAP  
Clinical Associate Professor  
Department of Medicine  
University of Hong Kong |
| 23 Sept 2021| Drug Prescribing in Renal Failure                                      | Dr. Anthony Kai-ching HAU  
Associate Consultant  
Department of Medicine & Geriatrics  
Tuen Mun Hospital |
|            | ABC of Peritoneal Dialysis Therapy                                     | Dr. Joseph Ho-sing WONG  
Associate Consultant  
Department of Medicine  
Queen Elizabeth Hospital |
| 30 Sept 2021| Update on Diabetic Nephropathy                                         | Dr. Maggie Kam-man MA  
Associate Consultant  
Department of Medicine  
Queen Mary Hospital |
|            | Update and Management of Chronic Kidney Disease                       | Dr. Wing-fai PANG  
Associate Consultant  
Department of Medicine & Therapeutics  
Prince of Wales Hospital |
| 7 Oct 2021 | ABC of Renal Transplantation                                           | Dr. Wai-yen LAU  
Associate Consultant  
Department of Medicine & Geriatrics  
Alice Ho Miu Ling Nethersole Hospital |
|            | Update and Management of Hypertension                                 | Dr. Ka-fai YIM  
Associate Consultant  
Department of Medicine & Geriatrics  
Princess Margaret Hospital |

**Date:** 2, 9, 16, 23, 30 September & 7 October, 2021 (Every Thursday)

**Duration of session:** 1.5 hours (6 sessions)

**Time:** 7:00 pm – 8:30 pm

**Course Feature:** Video lectures (with Q&A platform for participants to post the questions)

**Quiz for doctors:** To be in line with the CME requirements for video lectures, DOCTORS are required to complete a quiz after the completion of each lecture.

**Language Media:** Cantonese (Supplemented with English)

**Course Fee:** HK$1,000

**Certificate:** Awarded to participants with a minimum attendance of 70% (4 out of 6 sessions)

**Deadline:** 25 August 2021

**Enquiry:** The Secretariat of The Federation of Medical Societies of Hong Kong  
Tel.: 2527 8899  
Fax.: 2865 0345  
Email: vienna.lam@fmshk.org

CME / CNE Accreditation in application

Online Application from website: http://www.fmshk.org
Injection Therapy in Sports Injuries, Where Are We? Where Are We Headed?

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Specialist in Orthopaedics and Traumatology
Associate Consultant, Department of Orthopaedics and Traumatology, Alice Ho Miu Ling Nethersole Hospital
Honorary Clinical Assistant Professor, The Chinese University of Hong Kong
Council Member, Hong Kong Association of Sports Medicine and Sports Science

INTRODUCTION
Injection therapies are one of the popular non-operative treatment modalities in Sports medicine for conditions including tendon injuries, ligament injuries, cartilage injuries and osteoarthritis (OA). Intra-articular hyaluronic acid (IAHA) has been the recommended treatment of choice for OA of the knee for more than 20 years; there has also been increasing interest in the use of biological products, including platelet-rich plasma (PRP) and stem cells, in treating many musculoskeletal conditions.

HYALURONIC ACID

What is Hyaluronic Acid?
Hyaluronic acid (HA) is a glycosaminoglycan, which is naturally present in synovial fluid and provides viscoelastic properties for the fluid. There is a decrease in the quantity of HA in synovial fluid during the progression of OA,1 which correlates clinically with joint pain and functional deficit.2

Mechanism of Action
In the early 1990s, Balazs hypothesised the use of IAHA to replenish the viscoelasticity of the degenerated synovial fluid. This hypothesis forms the foundation for the evolving “viscosupplementation” concept;3,4 the latter proposes that IAHA can improve the lubrication in the joint. At the cellular level, IAHA helps to lessen pain mediator formation, enhance endogenous HA production, decrease HA degradation and protect against chondrocyte loss. The regimen of IAHA differs in different products, ranging from a single shot to multiple sequential injections each at one-week intervals.

Clinical Efficacy

Various meta-analyses5-7 have shown the clinical efficacy of IAHA in OA of the knee. The effect size of IAHA in treating OA of the knee is at least comparable to or even better than common oral analgesics9 in terms of pain relief and functional improvement.

However, there is no evidence to support the generalised use of IAHA injection in other major joints, including shoulder, hip and ankle joints.

Safety
A systemic review and network meta-analysis10 involving 18 HA products and 13,042 patients aged 45 to 75 years found a low rate of adverse events from IAHA. Transient local reactions such as pain, erythema and swelling were the most common adverse events, being reported in 8.5% of the cohort. In 37 studies involving 13 products and 5,550 patients, the incidence of patients withdrawn due to adverse events was low, ranging from 0 to 4.4%.

Controversies
Even though the use of IAHA has been recommended by various professional organisations all over the world11-14, the American Academy of Orthopaedic Surgeons (AAOS) does not recommend the use of IAHA in patients with symptomatic OA of the knee.15 This stand of the AAOS arises from possible publication bias in the available literature such that the overall effect of IAHA could not achieve the minimum clinically significant improvement in patients.

Conflicting clinical findings could likely result from variations in concentration, molecular weight, and injection protocol in different HA products.

Further high-quality study is needed to determine the patient phenotype and disease subgroup that would best benefit from IAHA. Future research direction in IAHA should target potential disease-modifying and joint-replacement-sparing properties of IAHA, long term effects of repeating injections and efficacy of combination treatment using different injection agents.

PLATELET-RICH PLASMA

Platelet- rich plasma (PRP) in the literature refers to a group of biological products including autologous conditioned plasma, platelet-enriched plasma, platelet-rich concentrate, autogenous platelet gel, platelet releasate, platelet rich in growth factors (GFs) etc.16

PRP contains an abundant amount of growth factors and cytokines that can stimulate cell migration, cell proliferation, angiogenesis and matrix synthesis.17 It helps to initiate and promote healing in various kinds of musculoskeletal injuries, including tendon, ligament and cartilage injuries.

Mechanism
PRP is usually prepared by using commercial kits and a centrifuge machine on autologous blood. After withdrawing and centrifuging the blood sample, the middle thin layer, which is the PRP, will be taken. Once the liquid form of activated PRP is injected, it forms a
transient fibrin scaffold and gradually releases growth factors at the site of infiltration. Growth factors will then stimulate various cellular cascades leading to tissue remodelling.

**Clinical Efficacy**

With its property of arousing tissue healing, PRP injection is potentially a promising treatment for osteoarthritis, tendon injury and ligament injury.

**Osteoarthritis**

Several randomised controlled trials (RCT) showed a positive effect of intra-articular PRP injection, in terms of pain control and improving joint stiffness and physical function, when compared with IAHA or placebo for the management of OA of the knee. More recent studies support the use of leucocyte-poor PRP (LP-PRP) in the place of leucocyte-rich PRP (LR-PRP) in the treatment of OA of the knee. Conceivably, the higher leucocyte concentration induces a more inflammatory response, which in turn promotes tissue healing, but such an inflammatory response may not necessarily be desirable in the context of managing OA of the knee.

**Tendon Injury**

Various growth factors in PRP may help in tendon healing by interacting with the tenocyte and extracellular matrix.

Lateral epicondylitis, also known as tennis elbow, is chronic overuse tendinopathy of the lateral elbow extensor tendons. There have been various studies comparing the effect of PRP with placebo, or with corticosteroid injection, or with other forms of conservative management in patients with lateral epicondylitis. Johal et al. published a systematic review and meta-analysis of 78 RCTs on the use of PRP in musculoskeletal injuries. The authors concluded that PRP leads to a reduction in pain; the available evidence supports the use of PRP in the management of lateral epicondylitis.

Houck et al. reported in his systematic review that PRP is effective in the treatment of lateral epicondylitis in the intermediate term, while corticosteroids improve the functional outcome and pain relief in the short term.

Patellar tendinopathy is also a common chronic overuse tendon disorder. A recent systematic review and metaanalysis on non-surgical treatments of patellar tendinopathy concluded that multiple PRP injections may offer more satisfactory results at long-term follow-up than other non-surgical treatment modalities and can be therefore considered a suitable option for the treatment of patellar tendinopathy. However, the authors also commented that the 70 studies included were generally with poor study quality.

Achilles tendinopathy commonly affect our athletes, especially runners. Nauwelaers et al. published a systematic review with meta-analysis on 4 RCTs. They concluded that PRP has no clear additional value in the management of chronic midsubstance Achilles tendinopathy and, therefore should not be used as a first-line treatment option. Other potential use of PRP include ulnar collateral ligament injury, plantar fasciitis, meniscal tear, augmentation in rotator cuff repair, augmentation in anterior cruciate ligament (ACL) reconstruction and muscle injuries. Further high-quality studies are necessary to verify the clinical efficacy of PRP injection in these conditions.

**Controversies**

Despite the promising clinical results of PRP in the treatment of OA of the knee, international guidelines, including those issued by AAOS and the National Institute for Health and Care Excellence (NICE), suggested that there is still inconclusive evidence to support the use of PRP for OA of the knee. More high-quality studies are warranted to refine the optimal concentration of leucocyte, concentration of platelet, proportion of leucocyte subtype, severity and characteristics of the patients suffering from OA who will benefit from PRP injection.

**STEM CELLS**

Stem cells are undifferentiated cells that are capable of division and differentiation into specialised cell types. These characteristics render stem cells the potential for tissue repair and regeneration.

In treating musculoskeletal disease, mesenchymal stem cells (MSCs) and bone marrow aspirate concentrate (BMAC) are currently the potential candidates to be used in clinical settings.

MSCs are able to differentiate along the mesodermal lineage, which includes the osteoblasts and the chondrocytes. MSCs’ potential disease-modifying function is believed to be via manipulation of the local environment by paracrine signalling rather than via direct differentiation of MSCs. Additionally, MSCs offer their anti-inflammatory and immunomodulatory function via anti-inflammatory cytokine expression, monocyte maturation inhibition and inflammatory T-cell suppression. Common human source of MSCs include bone marrow, adipose tissue, skeletal muscle and umbilical cord blood. Up to date, no MSC therapies have been approved by Food and Drug Administration (FDA) for clinical use in musculoskeletal disease.

Unlike MSCs, which depend upon laboratory manipulation and culture expansion to isolate and augment cell populations, BMAC only requires centrifuging process with commercial kits similar to that of PRP. BMAC is usually classified as minimally manipulated autologous blood products, with a mixed cell population and lower prevalence of progenitor cells. In contrast to MSCs, BMAC is cleared by the FDA for the clinical use in musculoskeletal disease.

**Clinical Efficacy**

**Osteoarthritis**

There are numerous preclinical studies on the use of cell therapy in OA of the knee. However, few high-quality studies reported its use in the clinical setting. Jo et al. reported the safety and efficacy of autologous adipose-derived MSCs injection, which could reduce...
knee pain and improve knee function at a 2-year follow-up. However, a recent meta-analysis\(^\text{10}\) concluded that MSCs only significantly impacted self-reported physical function but not self-reported pain level. Furthermore, the functional benefit could only be demonstrated in patients who underwent concomitant surgery. Another review,\(^\text{11}\) involving 18 clinical studies (including 4 RCTs), concluded that there are promising results in terms of safety and effectiveness of BMAC injections for the treatment of OA of the knee.

### Tendon Injury

A recent systematic review\(^\text{8}\) 8 low-quality studies on the use of stem cells in rotator cuff tear, Achilles tendon injury, patellar tendinopathy and elbow tendinopathy, concluded that there is only level 3 evidence to support the efficacy of stem cell therapy for tendon disorders. Evidence-based recommendations for the use of stem cell therapy for tendon disorders in clinical practice cannot be made\(^\text{12}\) due to considerable risk of bias in current available studies.

### Controversies

There is still limited evidence to support the large-scale use of stem cell therapy in musculoskeletal disease in view of significant heterogeneity among the studies, the small sample size, short-term follow-up, and overall poor methodology in the currently available studies. Many aspects remain to be clarified in order to optimise the potential of stem cell use in musculoskeletal cell therapy, including long-term safety, method of harvest and preparation, dosage of injection, timing of injection, and delivery method.

### CONCLUSION

There is growing interest in the clinical use of hyaluronic acid injection and biological therapies in musculoskeletal disease. Studies show there is positive result in terms of safety and clinical efficacy. However, there is still a significant knowledge gap before we could rationalise their generalised use in clinical practice. Clinicians must be well-equipped with the scientific evidence when counselling a patient about the use of these modern non-surgical treatment options for musculoskeletal disease.

### References

Hong Kong U21 Team

2022 World Lacrosse Men’s U21 World Championships taking place in Limerick, Ireland! The Hong Kong U21 Team will compete with other 22 countries in August next year.

HKLA Gym & Strength & Conditioning Team

The gym was designed and built for the needs of an elite Lacrosse program and this space is for the exclusive use of players in our elite programs.

Our S&C coaches works to equip our players with specific training program, so to improve athletes performance on the field.

New HKLA Membership available in Aug

Facebook | Instagram | Twitter | @hklacrosse | YouTube | Hong Kong Lacrosse Association
I am Dr Jonathan Yuen, an associate consultant in the Department of Orthopaedic and Traumatology in Tseung Kwan O Hospital, but at the same time, I am also the team doctor of Hong Kong Lacrosse Association (HKLA) since 2013.

American Academy of Orthopedic Surgeons (AAOS) has a definition for "Team Doctor" - Team doctors carry the leadership role in the organisation, management and provision of care to athletes involved in individual, team or mass-participation sporting events.

That is the official answer for what a team doctor does; but in most cases, as it is with me, working with a sports organisation as a physician, we learn our role by fulfilling it as we go along.

When I look back at my personal journey of learning to be a team doctor, I saw myself going through three main phases, which I would like to share with you here.

PHASE ONE:
WHEN YOU FIRST STARTED...

The journey of being a team doctor starts when you decide to walk out of your consultation room and onto the field. It is a period where most of your work is reactive since you do not have much experience in this area and you are constantly in a problem-solving mode.

Here are a few key features that I think are important in this phase.

Knowing the Sport
You need to know what to expect and look for when you are working with athletes, as knowing the sport allows you to understand the needs of the athletes and to establish a better rapport with them when they come to you for help. Better understanding of the sports and needs of athletes also reduces mental stress on yourself when you are doing sideline support on the field, when a million things are happening simultaneously, especially for team sports. The more you know the sport, the more you know where and what you should put your focus on.

Working with Various Stakeholders
Rather than just working with fellow doctors and nurses who usually speak the same language as you working with a sports team means working with coaches, trainers, athletes, physiotherapists, team managers and administrative staff. Each and every stakeholder has their agenda, priorities and preferred way of communication. If you aspire to be an effective team doctor, you need to juggle your way through these various team members and bring your priority, which is the well-being of the athletes, to the negotiation table and hold your ground.

Understand your Limits and Appreciate all Knowledge and Methods Available
Sports medicine is an ever-evolving science, and athletes search for anything that can make them perform better. As a team doctor, you need to be humble about the fact that you do not know all the possible treatments in the world. Instead of saying "no" to things you are not familiar with, you should use your knowledge to help the athletes to pick the best informed choice for them, even when it may not be the one that you learned from medical school. I always felt like a team doctor; I learn more from my athletes, trainers, and therapists than myself.

Establish a Vibe as a Team Physician
In order for the team to work with you, they will need to know what to expect from you. So be proactive and upfront about why you are here, be consistent with your work and always keep your doors open. Your proactivity and open mind will encourage
communication, which in time will establish not just your authority in the team but also the trust in you.

Once you have defined your identity as a team doctor, having a hold of what you do on and off the field and gaining your team’s trust, you will move on to the next phase.

**PHASE TWO: WHEN YOU BECOME A VETERAN…**

In this phase, you are at ease in handling most complaints and needs from the team, so you start to have the mental capacity to think further about making your life easier. The team doctor at this stage should be taking a more leading role in the team and try to be more proactive by foreseeing problems before they arise.

Key features in this phase include:

**Be a Good Lobbyist**

You need to convince your team the medical side of the game is almost as important as the game itself. Put injury prevention programmes in place, add them into drills in practices. Get the resources from your association to drive various programmes and policies like pre-season screening, athletes education and getting different expertise into your medical team. Coaches and players also have to be on board to ensure the best compliance and greatest impact from your work.

**Team-building**

Supporting a sports team is not a one-man job (if possible); you need to build your own team of personnel to help you do your job while not forgetting to help them develop affection and passion towards the sports team. What sort of help you need will be determined by how well you know the strength and weaknesses of yourself, and the need of your athletes. It can vary from physiotherapist, sports trainer, and strength & conditioning coaches, etc.

**Cultivate Every Individual Relationship**

You need to know your athletes and even coaches well enough for them to approach you when they have a problem. You need to know them and the team well enough to let them believe you will understand their situation no matter if it is a sports injury or bigger tasks such as advice on practice planning or anti-doping issues.

**Close-loop Communication**

Adding onto the previous point, all actions and policies a team doctor makes affect everyone in the team or association; therefore, continuous feedback from your players, coaches, therapists, managers and office staff is of utmost importance to avoid any misunderstanding and to allow fine-tuning of your work.

If you can juggle all of the above agendas, you would have become a valuable member of the team and, to a certain extent, have lived up to the definition of “team doctor” from AAOS.

**PHASE THREE: WHEN YOU ARE RUNNING OUT OF THINGS TO DO…**

Now you are at a stage where you feel comfortable in the team and association. Everyone values your opinion and follows your lead; with a strong comprehensive medical team supporting your work, you are more hands-off in terms of day-in-day-out matters.

One can certainly stop there; no one could blame you for sitting back a bit enjoying the fruits of your work. But given a team doctor is surrounded by athletes and coaches who are endlessly chasing after better performance and better results, you certainly will be infected with that mentality and would undoubtedly look forward to what should be the next step to take to better yourself.

Personally, I am still exploring as I go along, working with the belief that I need to develop sustainability,
meaning if one day I am no longer with the team, systems and workflows would have been set in place, and my physical presence and contribution will no longer be essential.

Since there is still so much more to be done, I have not rendered myself completely redundant yet. Here I will share a few things I am doing or planning to do.

**Injury Reporting and Management Framework**

Currently, Hong Kong Lacrosse Association is running a self-developed web-based platform called Sports Injury Management System, aka SIMS, to help our medical team to manage all our players in the elite programmes.

Some of the functions of the platform include:

1. Keeping a record of all pre-participation screening forms and assessments, allowing easy review of players’ background and past histories for management of any new injuries.

2. Injury reporting, which can be done by players or therapist/coaches, aiming to encourage players to have the habit of coming forward to seek help earlier after an injury. Injury data collected will also be reviewed and analysed after each season to facilitate better programme planning and injury prevention measures.

3. Via SIMS, various parties including doctor, therapists, coaches and players can communicate with each other concerning the management of an active injury in a player. SIMS facilitates a multi-disciplinary approach to treatment and rehabilitation of the injured, in an attempt to achieve seamless flow from the time of injury to the day of a full return to the sport. Out of concern for patient privacy, different personnel will be granted different levels of access to information.

4. Via the system, sorting of manpower for on-the-field support for all practice sessions and tournaments, and performing the accounting work for claim forms for expenses, thus greatly reducing the number of emails, WhatsApp and paperwork throughout a busy season.

**Sideline Support / First-Aid Education**

Education will no longer be just to players, but to other team members including coaches, trainers and staff who run the association’s programmes of different skill levels. Reaching out to as many stakeholders as possible is one way to cultivate the awareness of the medical part of the sport.

**Find your Successors**

Always look for someone to take your job; it can be from outside, by promoting your sport and by sharing what you do every time you have the chance. Mentor that person and leave nothing to yourself.

Finally, I have to say the paycheque of a team doctor is in the currency of the success of your athletes, the trust your coaches and team members have in you, and the enjoyment of working with the people you have surrounded yourself with. As a medical practitioner, I feel there is no better form of reward than that.
The Revelation: Myths of a Doctor’s Daily Routine at the HKSI

Dr Bryan Siu-fung LAU

MBChB (CUHK), DFM (HKCFP), MScSMHS(CUHK)
Honorary Clinical Assistant Professor, The Jockey Club School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong
Part-time Lecturer, Department of Orthopaedics and Traumatology, Faculty of Medicine, The Chinese University of Hong Kong

INTRODUCTION

After receiving the Master of Science degree in Sports Medicine and Health Science at the Chinese University of Hong Kong, I had the fortune to practise Sports medicine in various capacities. Eventually, I worked closely with elite athletes at the Hong Kong Sports Institute (HKSI). The HKSI was a ‘mysterious sports palace’ to me and many others, including young medical professionals interested in making Sports medicine their future career path. In this article, I will introduce the salient features in the doctor’s roles and responsibilities at the HKSI, as opposed to providing care in the form of a once-off medical opinion for an athlete’s injury or illness.

Designated by the HKSAR Government to provide a high-performance training system for eligible sports, the HKSI currently supports over 1,200 Scholarship Athletes (including para sports). A variety of clinical services are provided, including regular outpatient clinic consultation, periodic health evaluation and outreaching medical team support for the HKSI teams in major national games.

The mixed clinical complaints of illnesses and injuries in the HKSI outpatient clinic are extraordinary. The patient group consists of young active elite athletes who are highly motivated and goal-oriented, having a congested training schedule and frequent overseas travelling plans. Given that the sports coach and the relevant sports association are also involved in the decision-making process, medical advice is usually based on teamwork approach.

SPECTRUM OF ILLNESSES IN SPORTS MEDICINE

The most common cause of acute illness is an upper respiratory tract infection, followed by an infection of the digestive system, skin or subcutaneous tissues, and particularly among the para sports athletes, the genitourinary system. The disease pattern in the HKSI Clinic is very similar to the epidemiology of acute illness in elite-level athletes during an international competition. Although it is commonly treated as a minor health issue in public, acute infectious illness results in a significant health burden to the athlete. The detrimental effects on athletes include subsequent reduction in sports performance due to muscle wasting and to a decrease in isotonic and isometric muscle strength, an interruption to the training timetable and an increase in the likelihood of injury during the competition. Some athletes may even end up missing important competitions which have been prepared for over the years.

The majority of acute infective illnesses could be prevented. In order to prevent the athlete from getting sick, education, promotion and execution of evidence-based infection control policy such as hand hygiene and massive vaccination are important at the HKSI. Even as common as the influenza vaccination, the doctor will need to be cognizant of athlete-specific factors, such as planning vaccination in the context of peak training or the tapering period before a major competition; discussions will likely involve shared decision making with the athlete and the coach. It also becomes extremely crucial to quickly identify and isolate the sick athlete who is potentially infected by Coronavirus (COVID-19) since the year 2020, in order to protect not only the sick athletes but also their teammates, coaches, staff and other athletes who are staying on the same campus during the lockdown periods. As a gatekeeper and medical supervisor, the doctor at the HKSI should also be equipped with excellent communication skills to form close teamwork with the administrative staff, athletes, and coaches at the HKSI to execute these preventive strategies effectively.

SPECTRUM OF INJURY IN SPORTS MEDICINE

Apart from taking care of acute general infective illnesses, a classic clinic day at the HKSI would also involve providing medical consultation on acute and chronic sport-specific musculoskeletal injuries. For example, head concussion with the need of interval SCAT5 assessment for Rugby player; or tenderness over tibial tuberosity, which is compatible with Osgood Schlatter Disease among the growing adolescent athletes. Fortunately, we have a great multidisciplinary professional team at the HKSI working together for athletes’ injury prevention, management, rehabilitation and preparation for return to play; this team consists of an Orthopedic Surgeon, Sports Physiotherapist and Strength and Conditioning Coach. As the head coach is directly responsible for the athlete’s training and performance, it is essential to include their opinion in the decision making of management and rehabilitation plan, which is also the key to success for ensuring the athlete’s compliance. The typical dilemma in discussion with the athlete and coach is: Time for rehabilitation and health versus Time for training and medal. In the negotiating process, the doctor MUST be well familiar with the athlete and understand the uniqueness of
sports culture, working out of the comfort zone and shouldering the team’s burden in order to establish good rapport. While speaking the same ‘sports language’, being compassionate in the discussion and actively participating as part of the team are essential, we, as healthcare providers, should prioritise the athlete’s health securely and ethically at the same time.  

We cannot know everything. The knowledge of Sports medicine has grown broadly that we could not provide the best health care to our athlete’s injury without strong team support anymore, which is very much like participating in a sports team. As the case-in-charge and coordinator, doctors at the HKSI should take care of the athletes in different stages from injury, recovery and return to play. By giving medical advice and initiating interdisciplinary discussion with all the experts in the Elite Training Science and Technology Division at the HKSI, we aim to provide the best customised medical care for our athletes.

PERIODIC AND PRE-COMPETITION MEDICAL ASSESSMENT

To assess the health condition of the elite athletes and ensure their safety in high performance sports, an annual health evaluation is performed from December to March every year at the HKSI. Health questionnaire, physical examination, blood and urine tests as well as resting ECG and echocardiogram are also part of the evaluation to monitor the athletes’ body condition. The annual health evaluation helps to regularly assess the status of past injuries and chronic illness, screen the risk factors in sports participation (such as clinical features of Marfan’s syndrome), obtain baseline testing for body condition as well as promote health education. The annual assessment also provides an opportunity to review the current medication(s) and to brief the athlete on the most updated Prohibited List from the World Anti-Doping Agency (WADA).

Ritalin, for example, a common prescription for young athletes who suffer from Attention Deficiency Hyperactivity Disorder, is one of the prohibited medications in competition under the classification Stimulants S6 in the WADA Prohibited List 2021. Application for Therapeutic Use Exemption will be submitted to the Hong Kong Anti-Doping Committee to give the athlete the authorisation to use the medication for treatment.

One of the major purposes of periodic health evaluation is to identify the medical conditions that may render participation in sports contraindicated; for example, symptomatic pre-excitation with Wolff-Parkinson-White syndrome, with sudden cardiac death possibly being the first clinical manifestation. Several high-profile cases of sudden cardiac death globally and locally over recent years have stimulated a healthy debate about the pros and cons of using resting ECG in athlete’s health screening. Those against it point out that there is a high false positive rate, the cost is high and undue stress may be associated with further investigations of ‘abnormal’ results. In contrast, those in favour of the routine use of ECG argue that it is more sensitive and specific than the medical history and physical examination alone, and the use of “International Criteria for Electrocardiographic Interpretation in Athletes 2017” can improve the accuracy and efficacy of athlete’s ECG interpretation significantly. It is not uncommon to find sinus bradycardia with a heart rate around 40 per minute, or T wave inversion limited to lead V1-2 or voltage criteria of left ventricular hypertrophy in a typical athlete’ ECG at the HKSI. The international criteria serve as an accessible tool to assist doctors in Sports medicine in interpreting athlete’s ECG effectively, which unavoidably has become the most popular topic in the International Olympic Committee Course on Cardiovascular Evaluation of Olympic Athletes in recent years. Since 2020, a 12-lead resting ECG with interpretation using the aforementioned international criteria has been introduced as part of the periodic health evaluation and pre-competition medical assessment for elite athletes at the HKSI.

Although most medical conditions (e.g. hypertension) are not the absolute contraindications to elite sports participation, optimal control should be established prior to commencing intense training and competition; continuous medical evaluation is necessary to monitor the progress of the disease throughout the athlete’s career.

CONTINUOUS EDUCATION IN SPORTS MEDICINE

Being a physician, we should equip ourselves with updated knowledge. Akin to the spirit of our athletes in the HKSAR delegate, the doctor at the HKSI should be highly motivated in continuing education and should always be hungry for the most updated evidence-based knowledge in illness and injury prevention, sports-specific disease management, rehabilitation and athletic health evaluation. All the work we have done are to prepare our elite athletes to stand proud under the flag at the medal ceremony one day.

Through attending different international conferences in Sports medicine worldwide, such as visiting the Wimbledon Stadium in the U.K., the HKSI doctor builds up a global network of friends who are experts in various subspecialties in Sports Medicine. Future collaboration with various experts in Sports medicine in terms of clinical data sharing and research on Asian athletes is much anticipated.

CONCLUSION

The job nature of a doctor at the HKSI has been evolving over the past decade, from a primary healthcare provider to a more uniquely trained Sports medicine physician, in order to satisfy the growing expectation of comprehensive care for the HKSAR team. Working on our own is far from being good enough to provide better health care; therefore, the ability to efficiently work and communicate in a multidisciplinary team setting, where the team can direct proper multi-professional teamwork for the athletes, is extremely crucial for the best of care in the outpatient service.
References

Certificate Course on
Complaint Management 2021
(Video Lectures)

Objectives:
- Understand current regulatory system for healthcare professionals
- Recognise key elements in a fair complaint management process and system
- Familiarise with current developments in complaint management
- Gain confidence in management of adverse incident with media involvement
- Establish the patients’ needs through questions and listening
- Appreciate key skills and qualities needed to handle patient complaints effectively

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<td><strong>Complaint system</strong>&lt;br&gt;The rights-, interest-, and power-based complaint system&lt;br&gt;Complaint system design - with resolution and preventive focus</td>
<td>Dr. Ludwig TSOI</td>
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<td>24 Aug 2021</td>
<td><strong>Complaint – is somebody at fault?</strong>&lt;br&gt;Complaint system of Medical Council and other regulatory bodies</td>
<td>Dr. Robert LAW</td>
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<td>31 Aug 2021</td>
<td><strong>Media in complaint</strong>&lt;br&gt;Handling media in adverse events</td>
<td>Dr. Carl LEUNG</td>
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<td>7 Sept 2021</td>
<td><strong>Complaint management</strong>&lt;br&gt;Practical tips on handling complaints and how to survive a legal action</td>
<td>Ms. Suk-chong LEUNG, Ms. Asha SHARMA</td>
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<td>14 Sept 2021</td>
<td><strong>Complaint – what’s new</strong>&lt;br&gt;Just culture, open disclosure and apology handling</td>
<td>Dr. Kai-ming CHOW</td>
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<td>21 Sept 2021</td>
<td><strong>Patients’ complaint</strong>&lt;br&gt;Patients’ complaint avenue in HK&lt;br&gt;What motivate patients to complain&lt;br&gt;What they want and deserve</td>
<td>Dr. Kim-lian ONG</td>
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Date: 17, 24, 31 August & 7, 14, 21 September 2021 (Every Tuesday)

Duration of session: 1.5 hours (6 sessions)
Time: 7:00 pm – 8:30 pm

Course Feature: Video lectures (with Q&A platform for participants to post the questions)
Quiz for doctors: To tie in with the CME requirements for video lectures, DOCTORS are required to complete a quiz after the completion of each lecture

Language Media: Cantonese (Supplemented with English)

Course Fee: HK$1,000
Certificate: Awarded to participants with a minimum attendance of 70%
Deadline: 14 August 2021
Enquiry: The Secretariat of The Federation of Medical Societies of Hong Kong
Tel.: 2527 8898 Fax: 2865 0345 Email: vienna.lam@fmshk.org

CME / CNE / CPD Accreditation in application
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The Health Benefits of Great Outdoors

Dr Lobo HT LOUIE

DPE(Springfield)
Associate Professor, Department of Sport, Physical Education & Health, Hong Kong Baptist University

In Hong Kong, a total of 24 country parks have been designated for the purposes of nature conservation, countryside recreation and outdoor education. Since 1970s, these country parks have been governed by the Country Parks Ordinance, which provides a legal framework for the designation, development and management of country parks and special areas. (Fig. I)

According to the Centre for Diseases Control and Prevention of the U.S.A., spending time outdoors is a safer choice than staying indoors during the pandemic as there is less likelihood of being exposed to COVID-19 during outdoor activities. The outdoor natural environment not only offers many opportunities to be physically active, but also promotes mental health, stress reduction as well as overall wellness. Heart rate, blood pressure, and self-report measures have provided convincing evidence that spending time outdoors helps to reduce the experience of stress, and ultimately improve health. Meanwhile, the outdoor setting has also been adopted as a valuable learning site for young schoolchildren, including positive pro-environment attitudes, scientific learning, enhancement of motor fitness, and physical health. The outdoors can be described as an open and constantly changing environment, providing the potential for experiencing freedom, gross and boisterous movements, and contact with natural elements. It also allows children time for unstructured activities in nature, which is beneficial for children’s positive affect, attitudes towards nature, and pro-sociality. (Fig. 2)

Research has demonstrated the health benefits of participating outdoors, specifically psychological, sociological, educational, and physical benefits. Breitenstein and Ewert summarised the health benefits of the outdoor recreation model based on the previous studies, as shown in Table 1.

The green space is important for mental health; regular engagement is linked with longevity and decreased risk of mental ill-health. Being physically active outdoors has been associated with enhanced mental well-being. The older adults showed fewer depressive symptoms when they spent more time outdoors and were physically active. The study estimated that each additional weekly use of the natural environment could lower the risk of poor mental health by 6 per cent. A multitudes analysis assessed the regime of doses of acute exposure to green exercise required to improve self-esteem and mood (indicators of mental health). The researchers utilised the meta-analysis methodology to analyse 10 studies involving 1,252 participants. The overall effect size for improved self-esteem and mood was found to be significant and showed mental benefits from engagement in green exercise.

To summarise, the outdoors appears to be a great escape from the pandemic. Many health-related benefits can be gained through the close encounters with the natural outdoors; however, a risk management plan should be conducted in order to get everything prepared before setting out.
### Table 1: Health benefits of outdoor recreation, excerpted from "Health benefits of outdoor recreation: implications for health education" by Breitenstein and Ewert.22

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<th>Benefits of Outdoors</th>
<th>Examples of Specific Health Outcomes</th>
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<tr>
<td>Catharsis/Relaxation/</td>
<td>• Opportunities for shared activities with family and friends</td>
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<td>Stress Reduction/Novelty</td>
<td>• Getting “away from it all” as a means of coping with stress</td>
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<td>• A different setting allowing contemplation and a new perspective</td>
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<td>• Opportunities to improve cardiovascular fitness and achieve the desired weight</td>
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<td>• Increased self-esteem through improved fitness and body image</td>
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<td>Fitness</td>
<td>• Acquiring new skills, e.g. hiking</td>
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<td>• Developing leadership skills</td>
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<td>• Skills gained in problem-solving, decision making, creativity, etc.</td>
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<td>• Increased congruence between values/beliefs and behaviours</td>
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<td>• Increased ability to accept others and individual differences</td>
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<td>Skills: Social, Leisure, Physical</td>
<td>• Increased confidence in the ability to make decisions concerning self, others and career</td>
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<td>• Ability to overcome restrictive sex role stereotyping, empowerment and network</td>
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<td>• Self-actualisation and locus of control</td>
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<td>Efficacy/Self-empowerment/Confidence</td>
<td>• Sense of calm or peace when in a natural setting</td>
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<td>• Cognition of interrelatedness of man and natural</td>
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<td>Transformational Cognisance:</td>
<td>• A sense of awe at the majesty of the universe, a sense of openness with nature and natural forces</td>
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<td>Awareness of environment and self</td>
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### References


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http://www.fmshk.org/rental
# Medical Diary of July

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<td>Live Lecture - Tailor-Made BPH Treatment: Data Update and Experience Sharing - Online</td>
<td>Certificate Course on Allergy 2021 (Video Lectures)</td>
<td>Certificate Course on Cytogenomics 2021 (Video Lectures)</td>
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| 3 SAT (4 SUN) | FMSHK ASM 2021 | Ms. Jovan CHUN  
Tel: 2527 8988 |
| 6 TUE | Live Lecture | HKMA CME Dept.  
Tel: 3108 2507  
1 CME Point |
| 7 WED | Live Lecture | Ms Antonia LEE  
Tel: 3108 2514  
1 CME Point |
| 8 THU | Live Lecture | Ms Elise HAW  
Tel: 9949 3079  
1 CME Point |
| 9 FRI | Live Lecture | HKMA CME Dept.  
Tel: 3108 2507  
1 CME Point |
| 10 SAT | Live Lecture | Ms Antonia LEE  
Tel: 2527 8988 |
| 12 MON | Live Lecture | HKMA CME Dept.  
Tel: 3108 2507  
1 CME Point |
| 13 TUE | Live Lecture | Ms Candice TONG  
Tel: 3108 2513  
1 CME Point |
| 14 WED | Live Lecture | Dr Calvin MAK  
Tel: 2995 6456  
1.5 CME points |
| 15 THU | Live Lecture | Ms Antonia LEE  
Tel: 3108 2514  
1 CME Point |
| 16 FRI | Certificate Course in Allergy 2021 (Video Lectures) | Ms Antonia LEE  
Tel: 2527 8988 |
| 19 MON | Certificate Course in Allergy 2021 (Video Lectures) | Ms Antonia LEE  
Tel: 2527 8988 |
| 20 TUE | Certificate Course in Allergy 2021 (Video Lectures) | Ms Antonia LEE  
Tel: 2527 8988 |
| 21 WED | Live Lecture | HKMA CME Dept.  
Tel: 3108 2507  
1 CME Point |
| 22 THU | Live Lecture | Ms Antonia LEE  
Tel: 3108 2514  
1 CME Point |
### Calendar of Events

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| **22 THU**  | 7:00 PM  | HKFMS Foundation Meeting  
Organiser: The Federation of Medical Societies of Hong Kong;  
Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong | Ms Nancy CHAN  
Tel: 2527 8898 |
|             | 8:00 PM  | HKFMS Foundation Meeting  
Organiser: The Federation of Medical Societies of Hong Kong;  
Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong | Ms Nancy CHAN  
Tel: 2527 8898 |
| **23 FRI**  | 2:00 PM  | Live Lecture  
Weight Loss Surgery for Diabetes - Online  
Organiser: HKMA-KLN City Community Network  
Speaker: Dr Dennis Chung-tak WONG | Ms Candice TONG  
Tel: 3108 2513  
1 CME Point |
|             | 7:00 PM  | Certificate Course in Allergy 2021 (Video Lectures)  
Organiser: The Federation of Medical Societies of Hong Kong  
Speaker: Dr Agnes SY LIUNG | Ms Vienna LAM  
Tel: 2527 8998 |
| **26 MON**  | 7:00 PM  | Certificate Course on Cytogenomics 2021 (Video Lectures)  
Organiser: The Federation of Medical Societies of Hong Kong  
Speaker: Dr Chris Tsun-leung CHAN | Ms Vienna LAM  
Tel: 2527 8998 |
| **27 TUE**  | 2:00 PM  | Live Lecture  
HKMA-GHK CME Programme 2020  
Topic: When medication don’t work in rhinitis patients (Online)  
Organiser: Hong Kong Medical Association & Gleneagles Hong Kong Hospital  
Speaker: Dr Winnie KAN | HKMA CME Department  
Tel: 2527 8452  
1 CME Point |
|             | 7:00 PM  | Certificate Course on Childhood Arthritis and Rheumatic Disease II (Video Lectures)  
Organiser: The Federation of Medical Societies of Hong Kong  
Speaker: Dr KWOK Piu-lee | Ms Vienna LAM  
Tel: 2527 8998 |
| **29 THU**  | 2:00 PM  | Live Lecture  
Certificate Course for GPs 2021 - Update on Management of Parkinsonism - Online  
Organiser: HKMA-KLN East Community Network, HA-United Christian Hospital & HK College of Family Physicians;  
Speaker: Dr CHEUNG Ka-yin | Ms Candidce TONG  
Tel: 3108 2513  
1 CME Point |
|             | 2:00 PM  | Live Lecture  
Local Clinical Experience on Obesity Management - Online  
Organiser: HKMA-HK East Community Network  
Speaker: Dr Michele Mac-an Yuen | Ms Vienna LAM  
Tel: 2527 8998 |
| **30 FRI**  | 2:00 PM  | Live Lecture  
Fracture Prevention in Postmenopausal Osteoporosis Women  
Organiser: HKMA-Shatin Community Network  
Speaker: Dr Henry Wing-ming KONG | Ms Candidce TONG  
Tel: 3108 2513  
1 CME Point |
|             | 7:00 PM  | Certificate Course in Allergy 2021 (Video Lectures)  
Organiser: The Federation of Medical Societies of Hong Kong  
Speaker: Dr Jalme S Rosa Duque | Ms Vienna LAM  
Tel: 2527 8998 |
Answers to Dermatology Quiz

Answers:

1. The diagnosis is pityriasis amiantacea, and the possible differential diagnoses include scalp dermatitis, psoriasis, seborrhoeic dermatitis and tinea capitis. Head lice and lichen simplex chronicus should also be considered. Pityriasis amiantacea is characterised by thick yellowish scales wrapping around the tufts of hairs. It may be complicated by secondary bacterial infection, especially when the condition is associated with psoriasis and seborrhoeic dermatitis. Topical steroids are useful containing salicylic acid, coal tar or sulphur may reduce the scales and inflammation. Antifungal shampoo such as ketoconazole shampoo is often prescribed if the secondary bacterial infection is suspected. Oral antibiotics are needed if especially when the condition is associated with psoriasis and seborrhoeic dermatitis. In general, mineral or vegetable oil such as olive oil may help to loosen the adherent scales. Shampoo associated diseases. In general, mineral or vegetable oil such as olive oil may help to loosen the adherent scales. Shampoo associated with seborrheic dermatitis.

2. Pityriasis amiantacea is diagnosed by its characteristic clinical features. No investigation is needed to confirm this condition from other possible associated diagnoses such as scalp dermatitis, seborrhoeic dermatitis, psoriasis, tinea capitis and so on, skin biopsy is necessary only rarely in a difficult case.

3. Treatment of pityriasis amiantacea depends on the specific associated diseases. In general, mineral or vegetable oil such as olive oil may help to loosen the adherent scales. Shampoo containing salicylic acid, coal tar or sulphur may reduce the scales and inflammation. Topical steroids are useful especially when the condition is associated with psoriasis or other forms of dermatitis. Oral antibiotics are needed if the secondary bacterial infection is suspected. Antifungal shampoo such as ketoconazole shampoo is often prescribed if associated with seborrhoeic dermatitis.

Dr Chi-keung KWAN
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Specialist in Dermatology and Venereology

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The HKFMS Foundation Limited

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The Hong Kong Medical Association
Relvar: Controlling asthma and its underlying inflammation.

Adverse effects observed with Relvar in clinical studies and post-marketing:

<table>
<thead>
<tr>
<th>Frequency Category</th>
<th>Number of Subjects</th>
<th>Adverse reaction(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very common ≥1/10</td>
<td>≥1/10</td>
<td>Headache, nasopharyngitis</td>
</tr>
<tr>
<td>Common ≥1/100 to &lt;1/10</td>
<td>1/100 to &lt;1/10</td>
<td>Pharyngitis, rhinitis, candidiasis of mouth and throat, pneumonia, arthralgia, pyrexia</td>
</tr>
<tr>
<td>Uncommon ≥1/1000 to &lt;1/100</td>
<td>≥1/1000 to &lt;1/100</td>
<td>Extrasystoles</td>
</tr>
<tr>
<td>Rare ≥1/10,000 to &lt;1/1000</td>
<td>≥1/10,000 to &lt;1/1000</td>
<td>Hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria, Palpitations</td>
</tr>
</tbody>
</table>

With Relvar, 25% more patients improve and achieve well-controlled asthma vs Bud/For and other ICS/LABA combinations in everyday practice.

Long-lasting molecules with sustained efficacy over 24 hours.2,5

High airway protection with low systemic effect.7

Implements all aspects of the ACT.6

If your asthma patients need an ICS/LABA, consider once-daily Relvar for proactive asthma control that lasts.8,10

Hypothetical patient used for illustrative purposes only.

The primary endpoint was the proportion of patients who achieved an improvement in ACT score from baseline of ≥3 or a total ACT score of ≥20 in patients in the PEA population initiated on Relvar or continuing on usual care at 24 weeks. The primary endpoint was met (p<0.001). Data presented are from a subset of patients prescribed ICS/LABA at baseline who were initiated on Relvar or continued on their ICS/LABA. Data showed a relative difference of 14% and an absolute difference of 14%.1,7

Reference:
**Well-tolerated Relief of Nociceptive Pain**

Fast onset of pain relief as early as 22 minutes, sustained for up to 24 hours.

Fewer upper and lower GI events compared with NSAIDs + PPI.\(^3\)\(^4\)

Noninferior CV safety compared with ibuprofen or naproxen.\(^5\)

---

**First-line Treatment for Neuropathic Pain**

Rapid and sustained pain relief from Day 2.\(^8\)

Low potential for pharmacokinetic interactions.\(^7\)

Significantly improved pain-related sleep interference and anxiety.\(^9\)

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**Abbreviations:** GI = gastrointestinal, NSAIDs = nonsteroidal anti-inflammatory drugs, PPI = proton pump inhibitor.

**References:**

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**LYRICA**

**Well-tolerated Relief of Nociceptive Pain**

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**References:**

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**FULL PROCEDURES AND INSTRUCTIONS ARE AVAILABLE UPON REQUEST.**