Family violence accounts for 25% of homicides in Hong Kong

To the Editor—Family violence (FV) is an important cause of homicide, of which an alarming example was a tragic event in Tin Shui Wai. In April 2012, a man killed his wife in a hotel and committed suicide by leaping. Another homicide-suicide incident in May 2012 led to two deaths and three injured by a man in mental relapse. What is the current situation?

About 50 homicides are reported annually by the Hong Kong Police Force.[1] Based on newspaper reports presented in a Family Violence Conference in 2010 in Tuen Mun Hospital, 165 FV-related homicides that occurred from January 1997 to June 2010 contributed to one quarter of the homicides reported by the local police. In all, these entailed 183 homicide victims (aged 0-84 years), of whom two thirds were females and one third were children. Notably, 46 assailants committed suicide leading to 229 deaths. Stabbing/chopping (31%) was the most frequent killing mode and the assailants were mainly parents (36%) and spouses (29%). Thus, FV is a sizeable public health problem with complex family dynamics and conflicts may not be readily discernible.[2] Identification of risk factors (low education level, unemployment, extramarital affairs, influence of alcohol, and mental illness) and triggers (separation, divorce, child custody, and insults about a partner's earning capacity/sexual ability) could serve an important role in prevention.[3] Nevertheless, certain barriers to danger assessment of local FV victims have been described, and include inadequate medical staff training, insufficient assessment time, and lack of medical social service support.[4] Escalation of FV may end up in death, of which FV-related homicide is an important indicator. A local monitoring system is urgently needed to guide the development of the pertinent government policies to remedy this situation.

CL Lau, FHKCEM, FHKAM (Emergency Medicine)
Email: terrycllau@yahoo.com
Department of Accident and Emergency Medicine, Pok Oi Hospital, Hong Kong
CW Kam, FRCS (Edin), FHKAM (Emergency Medicine)
Clinical Skills Training Centre, New Territories West Cluster, Hospital Authority, Hong Kong
Anna WM Choi, PhD, BA
Department of Social Work and Social Administration, The University of Hong Kong, Hong Hong
Janet YH Wong, RN, PhD
School of Nursing, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong
FL So, MSN
Department of Accident and Emergency Medicine, Tuen Mun Hospital, Hong Kong

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Alzheimer's disease biomarkers

To the Editor—In a recent review, Chu[1] described the importance of biomarkers in the diagnosis of Alzheimer's disease (AD). Indeed there is a paradigm change to a biomarker-driven diagnosis of AD as reflected by the revised National Institute on Aging and Alzheimer's Association criteria for AD published in 2011.[2] However, we would like to raise several caveats. First, there are various technical problems with the existing AD biomarkers,[3,4] eg poor standardisation and reproducibility across laboratories, so that universally agreed standards for determining abnormal results are not yet established. In addition, multiple brain pathologies frequently co-exist in dementia, and AD pathology does not necessarily correlate with clinical symptoms, making interpretation of the biomarker findings difficult. Second, availability and costs of the AD biomarkers pose challenges to our public medical services, where resources are already overstretched.[5] Third, the use of AD biomarkers only results in an incremental gain in the accuracy of diagnosis by an experienced clinician. The AD biomarkers are clearly a scientific advance, but further studies on their clinical utility and cost-effectiveness in the diagnosis of AD are required before their widespread clinical use. The scientific community should continue the quest for cheaper

and more available biomarkers with good sensitivity and specificity for the diagnosis. Furthermore, we believe that the priority for dementia care in Hong Kong is to provide early diagnosis and treatment for the rapidly growing number of patients. Policymakers should carefully formulate a policy that makes the best use of our resources to achieve these goals.

Helen FK Chiu, FRCPsych
Email: helenchiu@cuhk.edu.hk
Department of Psychiatry, Faculty of Medicine
The Chinese University of Hong Kong
SW Li, FRCPsych
Castle Peak Hospital
Hong Kong

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Authors' reply

To the Editor—In my recent review on 'Alzheimer's disease: early diagnosis and treatment', I have summarised the recent international research literature on biomarkers on Alzheimer's disease (AD).[1] The purpose of including the biomarkers section was to make local readers aware of their value. In the 2011 revised recommendations from the National Institute on Aging and Alzheimer's Association (NIA-AA) workgroups on diagnostic guidelines for Alzheimer's disease,[2] the core criteria for AD diagnosis were very similar to the previous 1984 clinical criteria for probable AD.[3] Without any biomarker, clinicians can still apply the core criteria to make a clinical diagnosis of probable AD. However, the addition of biomarkers for AD improves the sensitivity and specificity of AD diagnosis. Biomarkers are also useful for the differential diagnosis of other dementia subtypes or in mixed brain pathologies.[1] An accurate diagnosis of AD could guide the subsequent use of current symptomatic treatments for AD. The NIA-AA workgroups also recommend using biomarkers in research,[2] and guidelines on using biomarkers of AD are helpful in diagnosing mild cognitive impairment due to underlying AD as well as in preclinical dementia due to AD.[4,5] Certainly, the availability of diagnostic resources is still limited in Hong Kong. Currently, brain magnetic resonance imaging is available in most local hospitals and a semi-quantitative rating can be done.[1] The most expensive Pittsburgh compound B–positron emission tomographic brain scan is only available in one local private hospital. Cerebrospinal fluid biomarkers assays are still under development in some hospitals. Similar to other laboratory procedures, local laboratory standardisation and establishment of local reference values are important for all biomarkers, whether in Hong Kong or elsewhere. Future local research studies to confirm the validity of these biomarkers are recommended.

LW Chu, FRCP (Lond, Edin, Glasg), FHKAM (Medicine)
Email: lwchu@hkucc.hku.hk
Division of Geriatric Medicine
Department of Medicine
Queen Mary Hospital
Li Ka Shing Faculty of Medicine
The University of Hong Kong
Pokfulam, Hong Kong

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