The Hong Kong Geriatrics Society Newsletter

The Hong Kong Geriatrics Society

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May 2003 issue

Time to *Reflect* in the Era of SARS/SRS/CVP

At no time in history are we so disturbed and distressed by the recent new arrival of the "Severe Acute Respiratory Syndrome" (SARS), also named as "Severe Respiratory Syndrome" (SRS), or "Coronavirus-associated Pneumonia" (CVP).

On 15th March, 2003, four days just after the SARS outbreak in the Prince of Wales Hospital (PWH), I was invited to PWH to join in the round table discussion on ethical dilemmas in the annual conference of their Centre of Gerontology & Geriatrics. While the organizer thanked us for "risking our life" to PWH, nobody actually wore a mask then. At that time, we did not anticipate the subsequent serious impact of SARS on Hong Kong.

By the beginning of the last week of March, when the SARS war was threatening Hong Kong and the Middle East War was heated up, the collective wisdom of the Council has guided us to postpone our AGM and Annual Scientific Meeting (ASM). This difficult decision was made after I had discussed with Professor Langhorne and evaluated the risk/safety ratio of this action. I must thank Professor Langhorne for being so considerate and fixing a new date on 21st June for the ASM with us out of his busy schedule and within such a short notice. I do wish that this SARS crisis will end by then, so that we can gather our energy for the postponed ASM in June.

Message from the President

Editorial

The ***SARS*** attack has markedly disrupted our daily lives. With significant casualties, it appears to be contained. Life is back to usual but we all remember these two months of darkness. We are now reviving the activities of our Society. The ASM and AGM are re-scheduled on 21st June. Do mark your diary and come to support your Society. Hope that our foreign guests could come also. Our Society has released a document on SARS in the elderly for the press which is also published in our Newsletter. We also have an interview report with a nursing home owner from Canada and it is interesting to note his viewpoints on our local setting. Together with our other articles, we hope that your geriatric appetite can be whetted, after this big and nasty "feast" of SARS.

Mok CK

Elders have unfortunately been portrayed with a negative image in this era of SARS: old folks as "litter bugs" with poor personal and household hygiene, elderly persons as "hidden" vectors of SARS, elderly SARS patients as source of cross-infections in hospital because of their "behavioural problems." These all arise from ageism towards elders and ignorance of geriatric medicine and gerontology. Poor personal and household hygiene can be due to disabling diseases (like stroke, arthritis, etc.) and inadequate social support network, which need to be dealt with in its own right. The "hidden" SARS in elderly persons can be due to missed or delayed diagnosis because of failure to recognize the special presentations of infections in old age, especially so for clinicians who are trained to diagnose singular presentations of discrete disease and not experienced at recognizing the geriatric syndromes and the complex pattern of multiple pathology in old age. SARS patients with "behavioural problems" are often restrained in hospital, but how much attention is being paid to restraint alternatives (like attention to basic human needs) and to diagnosing "behavioural problems" as secondary to delirium due to infections, drugs, and electrolyte imbalance; which need to be promptly treated for reversibility. When an elderly patient and a health care worker in the same ward are discovered to have SARS, it is too often assumed that the elderly patient has infected the health care worker, but it can well be the other way round. Are our elderly patients adequately protected from SARS infection in the hospital setting? People accept without questioning when elders with chronic illness die. Can it be due to our ignorance in combating this new arrival, e.g. iatrogenesis from adverse drug reactions or heroic measures that elders often poorly tolerate.

When the unfortunate SARS elderly victim has to face death, how are the palliative needs of the elder and her family taken care of when there are barriers of isolation?

Even our elder medical professionals may be susceptible to this ageism unknowingly. Emeritus Professor Liu of Zhong Shan University has often been blamed for spreading the SARS beyond Guantong, though his selflessness is equivalent in caliber to Dr. Urbani, the WHO investigator of SARS. Despite being retired, this 64-year-old professor of Guantong returned to work in his mother hospital and had helped in treating over 300 SARS patients and finally was infected and succumbed. Similarly, I heard whispers of a local 56-year-old clinic doctor spreading SARS to his patients. The other side of the story is that this doctor, after seeing and referring around ten suspected SARS patients to an accident & emergency (A&E) department for treatment, finally presented to A&E himself with his own referral letter, "I refer myself for ?SARS." He succumbed ultimately in solitude, without the companionship of his wife, who was also afflicted by SARS and was being treated in another hospital. Seniors and elders have definite contributions in this era of SARS. Some of our humble elderly citizens, despite their advanced age, are toiling their bodies to improve the hygiene and cleanliness of Hong Kong.

How can geriatricians contribute to this SARS era? The versatility and holistic nature of our training means that geriatricians can play their role in combating SARS whether in acute, rehabilitation or community settings; diagnosing SARS despite of atypical presentations and multiple pathologies in old age, avoiding iatrogenesis in the midst of therapeutic uncertainties, attending to individual variations and needs of an elderly person rather than just focusing on attacking the pathogen and correcting the pathogenesis, as well as adopting preventive measures in aged homes to minimize further spread within the community. Since mid-March, there have been quite active e-mail discussions on SARS in elders among geriatricians. After the Easter Holiday, I think it is time for our Society to present our views to the public and our peers on SARS in elders from a geriatrics perspective, and thanks to the full support of the Council, we have our press release issued on 25.4.03, which is also published in this Newsletter. It is my intention to set up a special interest group under HKGS to pool and share all our experience and expertise in SARS in elders, so that we can keep the public or our peers well informed of the status of this new arrival from a geriatrics perspective. With the sudden new arrival of SARS, elderly patients without SARS might too readily be forgotten. Whether an elderly patient has SARS or not SARS, they are human beings longing for care and comfort.

In this era of SARS, when the acute tends to take precedence over the chronic, when the urgent drives out the needy, when quantity (like mortality and case rates) attracts more attention than quality (of care and life), when everybody is chasing with time to invent and publish, it is time to slow down and reflect, that science needs to be complemented by the often missing art for a harmonious life. Someone is quick to point out the important ingredients of S(acrifice), A(ppreciation), R(eflection), and S(upport) embedded in "SARS." Incidentally, the alternative name "SRS" reminds us that SARS may present as a blunted slow release syndrome (SRS) in elders, which if undiagnosed may lead to disastrous spread. An example of such outbreak involving unrecognized tuberculosis in a nursing home in the United States has been revealed by molecular and epidemiological links*.

The term 'geriatrics' was devised by Ignatz Loe Nascher (1863 – 1944), an American physician. In 1909, he created a special branch of medicine which he called 'Geriatrics', derived from two Greek words - geras (old age) and iatricos (relating to the physician).

Professor Bob Stout, President of BGS, BGS Newsletter 2003 March

[In his correspondence with Dr. TK Kong, our President, on this subject, Professor Stout opined that "geriatrics is a respectable word with a distinguished history and that it is our job to demonstrate the real meaning of the word and not to continually try to find new titles." He has provided Dr. Kong with copies of Professor George Adams' (Emeritus President of BGS) articles on the vision and mission of the early pioneers of BGS*. Members interested to read these can contact Dr. Kong.

* 1. Adams GF. Eld Health: Origins and destiny of British Geriatrics. Age Ageing 1974;3(4):1-3. (Part 1 of the Presidential Address to the British Geriatrics Society, Portsmouth, April 1974.)
2. Adams GF. Eld Health. (Part 2 of the Presidential Address to the British Geriatrics Society, Portsmouth, April 1974.)
3. Adams GF. Dr. Marjory W. Warren. (Memorial Address). Gerontologia Clinica 1961;3(1):1-4.]

We would do well to heed the advice of Sodhy in 1978 when he warned of the reemergence of tuberculosis in the older and the underprivileged after initial triumph in controlling its infectious spread, "Because of the transmissible nature of tuberculosis, no one is safe until all are safe; and until all are safe, the disease remains a blot on the conscience of the world community."

TK Kong

* Ijaz K, et al. Unrecognized tuberculosis in a nursing home causing death with spread of tuberculosis to the community. J Am Geri Soc 2002;50:1213-8.

Publication subcommittee:

Dr. Mok Chun Keung (Chairman)
Dr. Leung Ho Yin
Dr. Pang Fei Chau
Dr. Yu Kim Kam
Dr. Tsui Chung Kan
Dr. Ip Pui Seung

Press Release

Severe Acute Respiratory Syndrome (SARS) in Elders

Friday, 25 April 2003

Attention News Editors:

In response to the recent public discussions on the Severe Acute Respiratory Syndrome (SARS) in relation to elders, the Hong Kong Geriatrics Society would like to express the following views:

The Hong Kong Geriatrics Society observed that there has been a recent surge in the numbers of the elders being affected by SARS in Hong Kong. These elders often presented with atypical symptoms, making diagnosis very difficult. The Geriatrics Society noted that there is considerable limitation in applying the strict SARS definition from WHO to elders.

The strict SARS case definition and registry criteria require a body temperature of at least 38°C. However, some of the reported SARS cases in elders have body temperature below 38°C. Possible reasons accounting for this are inaccurate temperature recording when axilla or oral temperature are measured in elders. Rectal temperature or the more acceptable tympanic (ear) temperature are more accurate measures of the body temperature. Furthermore, because of the declining immune function due to ageing, disease, or drugs, elders often have blunted fever response to infections: there may be low-grade fever (less than 38°C), absent fever, or even hypothermia. Of the first series of 10 reported SARS patients in Canada, 3 had hypothermia (temperature 35.5°C to 36.5°C).

The symptoms listed in the SARS definition are: chills or rigors, cough, myalgia, malaise, diarrhoea, and contact history but these are often missing in the elders. Frail elders tend to present more typically as the geriatric syndromes (the so-called "atypical" presentations) and the picture may be further complicated by coexistence of multiple pathologies or diseases.

The geriatric presentations that are relevant for SARS are falls, incontinence, confusion and poor feeding. While an elder may not complain of any cough in the presence of pneumonia, a rapid breathing rate may be a first sign of pneumonia in old age. A bed-bound elder may have a normal respiratory rate on lying down, but with the slightest exertion such as when asked to sit up, the respiratory rate may go up.

Because of the frequent occurrence of multiple pathologies in old age, the diagnosis of SARS may be masked by alternative explanations of coexistence of other illnesses in old age: e.g. pneumonia in an elder with history of multiple old strokes and swallowing difficulty may be taken as aspiration pneumonia and the possibility of SARS ignored.

So, a diagnosis of SARS in old age requires a high index of suspicion, a knowledge of the geriatric presentations of infections in old age, a sensitivity to a frail elder with change in functional state and not fairing well after usual observation and treatment, and an alertness to any contact history of SARS or clustering of illnesses in her life-space zone (be it at home or in aged home).

There have been much discussion among the professionals and the public on the treatment strategies of this relatively newly discovered SARS. While scientific evaluation of these treatment strategies are awaited, we would like to point out the challenges in managing SARS in old age. Adverse drug reactions in old age are common. Thus elders are more vulnerable to the adverse side-effects of ribavirin and steroid commonly used to treat SARS. New drugs are often not well tested in elders and history is filled with lessons of serious adverse drug reactions when using new drugs in old age. The benefit to risk ratio of any given intervention may be quite different in frail elders with significant co-morbidities when compared to younger adults. Elderly people are heterogeneous, forming a continuum from fit elders to frail elders. So, an individualized approach is required in treating an elder with SARS, balancing the risk benefit ratio and appropriate to her condition and course of illness. An acute illness in an elder often results in reduced functional ability, so that a rehabilitative approach is important in returning them to the community.

While promotion of public hygiene is high on the agenda as an important measure to prevent cross-infection, some elders may be affected by adverse social circumstances like living alone, inaccessible to mass media, inadequate social network and handicapped by disabilities.

In the setting of aged homes, it is important also to promote on the awareness and compliance of aged home staff in maintaining proper hygiene and taking precautions in nursing procedures to prevent infection, such as changing feeding tubes, urinary catheter, and napkins. Since frail elderly residents of aged homes may have SARS under-diagnosed, contact tracing using the strict SARS definition have its limitations. Thus, we have to be alert to probability of SARS in elders recently discharged from hospitals, alert to clustering of any illnesses in space and time for residents, staff, visitors and outreach workers of a particular aged home, and this may mean careful recording of all those who fall sick (who, when, where) and watch out for clustering and links. This will mean close collaboration and communication among out-reach community geriatric service, community nursing service, and acute and rehabilitation hospital staff.

Dr TK Kong, the President of the Hong Kong Geriatrics Society said, "the aim of this press release is not to arouse further anxiety and panic among the public, but to call for better understanding, trust and patience from the public; as well as collaboration and harmonization among various sectors and professions in combating this new arrival of SARS for the benefit of Hong Kong." He further pointed out that it is important to treat our elders appropriately not only as a tribute to their past contributions to the society, but also for the global connectivity of mankind of whatever age - because of the transmissible nature of SARS, no one is safe until all are safe; and until all are safe, the disease remains a blot on the conscience of the world community.

Dr Kong also highlighted that SARS patients can be found not only in medical wards, but also in surgical wards, not only in acute hospital, but also in rehabilitation hospital, and also in community, including aged homes. Undiagnosed SARS elders can readily serve as vectors and spread the infections to their family members or health care workers taking care of them.

He also offered a few illustrative cases to highlight the difficulties and the risks inherent in the diagnosis and treatment of SARS disease in the elders in the Appendix followed.

The Hong Kong Geriatrics Society, formed in 1981, is a professional body consisting of 160 doctors interested in and specialized in the management of disease and disability occurring in elderly people.

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Further information could be obtained through Dr TK Kong, President, the Hong Kong Geriatrics Society, Tel 852 27498228 Fax 852 27440249 E-mail: tkkong@ha.org.hk

Appendix: Case illustrations

Case 1. SARS presenting as acute abdominal pain in an elder:
An elder was admitted into a surgical ward of an acute hospital for acute abdominal pain and an emergency operation was done. The elder was subsequently transferred to a medical ward because of fever, but deteriorated, resuscitated and finally died. Post-mortem revealed SARS. A doctor who has taken care of the patient in the surgical ward was infected with SARS and an outbreak of SARS occurred among the hospital staff in the medical ward.

Case 2. A 70-year-old woman with confirmed SARS presenting as fall with hip fracture:
A 70-year-old woman was admitted into an orthopaedic ward of an acute hospital for fall with fractured femur, operated, but then found shortness of breath and X-ray revealed lung shadows and initially thought to have aspiration pneumonia because she was predisposed to this by prior history of stroke with difficulty in swallowing. However, two doctors in that ward were unwell with fever and source of SARS was thus searched within that ward. The woman subsequently died and post-mortem confirmed that she had with SARS. Retrospectively, a physiotherapist who had worked with that patient recalled she had been unwell when working in that ward.

Case 3. An elderly woman with confirmed SARS presenting as fall with head injury:
An elderly woman was admitted to a neurosurgical unit of an acute hospital with fall and head injury was subsequently confirmed to have SARS also. The son who had visited that acute hospital also contracted the disease.

Case 4. Faecal incontinence in a 72-year-old man with SARS:
A 72-year-old man was admitted for fever, rigor and cough, and later diarrhoea with faecal incontinence. He was later confirmed to have SARS. Three nurses who have cleaned the patient during his faecal incontinence also got SARS

Case 5. A 75-year-old woman admitted for stroke and later had confusion and poor feeding likely due to SARS contracted from another patient hospitalized for SARS:
A 75-year-old woman was admitted into an acute hospital with stroke from an aged home. A patient admitted in a bed next to her had fever and cough, and lung shadows on chest X-ray and subsequently confirmed as SARS and transferred to an isolation room, but then deteriorated and transferred to intensive care. For safety reason, the elderly stroke patient was isolated as well. This stroke patient had fever kicked up 3 days later; the first chest X-ray was clear. Her fever subsided with antibiotics. However, on day 9 of isolation, she became confused, disorientated and was not eating well, despite that she had no fever. A repeat chest X-ray showed shadows in her right lung. Her total white cell count was normal but the lymphocyte count was low. She was treated as clinical SARS.

Case 6. An elderly stroke was transferred from an acute hospital to a rehabilitation hospital for rehabilitation. That stroke patient was complicated by pneumonia initially thought to be due to aspiration pneumonia. Subsequently a staff of that rehabilitation hospital had SARS, and the elder was also found to have SARS. The undiagnosed SARS patient had spread the infection to the staff.

Case 7. A 72-year-old woman presented with collapse; delayed features of SARS resulted in a major SARS outbreak among hospital staff:
A 72-year-old woman presented with collapse in the toilet. She attended Accident & Emergency Department and was admitted to an acute medical ward for confusion secondary to electrolyte disturbance. She had no fever on admission, but one day after admission, she had fever. Typical features of SARS appeared only 6 days after admission. More than 10 health care workers have been infected with SARS in that acute medical ward.

Case 8. An 82-year-old woman with SARS initially thought to have flu and urinary tract infection:
An 82-year-old woman had a fever of 38^{o}C, chills, and myalgia, was seen by a general practitioner, told clear chest on auscultation, was reassured to have a flu and given three days of antibiotics, panadol and vitamin C. She attended an Accident & Emergency Department on the fourth day because of fever of 38.5 ^{o}C and volunteered a sleepless night with frequency of small amount of concentrated urine despite liberal fluid intake. Uristix of urine showed mild abnormalities. X-ray of her lungs and her kidneys were normal. She was treated as urinary tract infection with another course of antibiotics. On the fifth day, she was seen by a geriatrician. Although she had no fever then, she still had malaise, reduced effort tolerance, and some sputum sticking in her throat (she did not complain of any cough). SARS was in the geriatrician's mind, and her urinary symptom was interpreted as due to reduced ability to excrete water load probably secondary to a lung problem. Blood tests revealed a normal total white cell count but low lymphocyte count, low serum sodium, and deranged liver function. A repeat chest X-ray was normal, but high-resolution CT scan revealed early pneumonic changes. SARS was thus confirmed clinically.

Case 9. An elderly resident of an aged home was admitted into an acute hospital and discharged a few days later. The elder returned to the aged home and was visited by her grandson. This elderly woman was readmitted into acute hospital with SARS confirmed, her grandson was ill with SARS and his brother was ill, and the kitchen worker of the aged home was also ill.

An interview with Mr. George Kaniuk

– Maple wood Nursing Home, Canada

Reported by Mok CK

(Q = Mok CK, A = Mr. Kaniuk)

Mr. George Kaniuk owns a Canadian company called Maplewood Nursing home Ltd which owns two nursing homes in Ontario. He came to Hong Kong to study the feasibility of setting up nursing homes here. He met many professionals in the field (including some of our council members) and also visited various geriatric facilities. He has kindly accepted a short interview with our Newsletter..

Q. What attracts you to come to Hong Kong?

A. I and my brothers have been running nursing homes in Canada for 30 years. It is the first time that I come to Hong Kong. It all starts when one of my staff told me about her unsatisfactory experience here. One of her elderly relatives was sick but had difficulty in finding a good quality nursing home except to queue up for the public ones which might take years. She encouraged me to come and see if it is feasible to set up nursing homes like ours in Hong Kong.

Q. What differences do you see between the two places?

A. Canadian nursing homes are heavily subsidized by the government, both public and private ones. We have set up an accreditation system for several years. Our license has to be renewed annually and the government inspection is very stringent. Home administrators are compelled to work to their best. Trained assessors also come annually to assess the "case-mix" of the nursing homes which would dictate the governmental funding to the homes in the coming twelve months. Hong Kong is probably going to develop in this direction.

Q. What hurdles do you see if you are going to set up nursing homes here?

A. First is the availability of land. Canada is very spacious and it is completely different in Hong Kong. Second is knowing the local need. As we are foreigners, we don't know where and what are the greatest need of such nursing home service in Hong Kong. The governmental rules and regulations are more or less the same as in our home country. Ours are actually more stringent. In order to get pass these hurdles, I has been advised to form joint venture with local facilities to make a start.

Q. What is your overall impression of nursing home services in Hong Kong?

A. I see that there are many variations in the standard of care. However, I was told that things are improving. More formal training is offered to Home staffs. I was very impressed by the dedication of the Home staffs that I met in these few days. They tried their utmost to improve the welfare of their inmates within quite limited resources. I will be most pleased if I can share my 30 year experience of nursing home running to a different geography as Hong Kong with very different jurisdiction and culture.

Q. Looking forward to seeing you sharing your great experience in Hong Kong in the near future.

A. Thank you.

Photo 1: Dr. Mok CK and Mr. George Kaniuk

Local and Overseas Scientific Meetings

Name	Time & Place	Organizer	Contact
Australian Society for Geriatric Medicine Annual Scientific Meeting 2003	16/6/03-18/6/03 Melbourne Australia	Australian Society for Geriatric Medicine	www.icms.com.au/asgm2003
Hong Kong Geriatrics Society Annual Scientific Meeting 2003	21/6/03 Golden Mile Hotel Hong Kong	Hong Kong Geriatrics Society	medicine.org.hk/hkgs/
2nd Congress of the European Union Geriatric Medicine Society	27/8/03 - 30/8/03 Florence Italy	EUGMS	www.mfgroupe.com
4th international symposium on Chinese Elderly	13/10/03 - 15/10/03 Beijing China	Peking U, Renmin U, Tsinghua U, HKU, OCIOA	Ageing@mail.ruc.edu.cn
British Geriatrics Society Autumn Meeting 2003	15/10/03 - 17/10/03 London UK	British Geriatrics Society	www.bgs.org.uk
The 7th Asia/Oceania Regional Congress of Gerontology	24/11/03-28/11/03 Tokyo, Japan	International association of Gerontology	www.convention.co.jp/7thaog

Editor's choice: Recent literature

Study of the relationship between cigarette smoking, alcohol drinking and cognitive impairment among elderly people in China (Age and Ageing 2003; 32:205-210)

3012 participants aged 60 and over were enrolled from 6 communities of Chongqing. The rate of abnormal cognitive function was 11.95%. Smoking and alcohol drinking are risk factors for cognitive impairment among elderly Chinese people. Cessation of smoking and reduction of alcohol drinking could be considered as part of a strategy to reduce the incidence of cognitive impairment.

The problems of sleep for older women: changes in health outcomes (Age and Ageing 2003; 32:154-163)

3-year longitudinal survey of 10,430 Australian women aged 70-75 years at baseline. A majority of women (63%) endorsed one or more items related to sleeping difficulty. 15% reported use of sleeping medication at follow-up. Sleeping difficulty is a common and persistent complaint among older women and is strongly associated with use of sleeping medications. Both behaviours are negatively associated with health status.

Effect of four monthly oral vitamin D3 (cholecalciferol) supplementation on fractures and mortality in men and women living in the community: randomised double blind controlled trial (BMJ 2003; 326:469)

A randomised double blind controlled trial of 100 000 IU oral vitamin D_3 (cholecalciferol) supplementation or matching placebo given every four months over five years to 2686 subjects aged 65-85 years living in the community. The regime was shown to be effective in reducing fracture.

Quality of spirometric performance in older people (Age and Ageing 2003;32:43-46)

Among 585 patients who were able to perform spirometry, the majority of elderly subjects can perform spirometry according to international guidelines; age itself can't be considered a risk factor for a bad spirometric performance but it becomes influential if it is associated with cognitive and functional impairment.

Effect of End Stage Renal Disease on the Quality of Life of Older Patients (JAGS 51:229-233, 2003)

The objective was to assess the effect of chronic renal failure on quality of life (QOL) and the design was a cross-sectional controlled study. In 13 dialysis units in the French Lorraine region, 169 older patients with end-stage renal failure (ESRF) who were starting first dialysis were recruited and 169 age- and sex matched non-CRF controls were recruited from six departments of Nancy University Hospital. SF-36 was used to assess QOL and other information was obtained from medical records. The QOL score of two has no significant difference and patients whose first dialysis was unplanned had 10.4 fewer points in the physical function dimension. It was concluded that ESRD in older patients has no more effect on QOL than others diseases. However, patients whose dialysis is unplanned have severely impaired QOL.

Pneumoncoccal Polysaccharide Revaccination: Immunoglobulin G Seroconversion, Persistence and Safety in Frail, Chronically Ill Older Subject (JAGS 2003; 51:240-245)

The study was to determine the 1-month postpneumococcal polysaccharide-revaccination immunoglobulin G antibody response, its persistence at 1 year, and tolerability of revaccination in frail, chronically ill older nursing facility residents. It was a prospective study conducted between December 1988 and July 2000. Sixty-seven subjects aged 65 and older received primary vaccination with pneumococcal polysaccharide vaccine at least 5 years before enrollment. The subjects were re-vaccinated with one dose of 23-valent PPV. The results showed a significant increase in aggregate median antibody concentration over baseline 1 month after revaccination. Minor, self-limited localized adverse reactions and systemic reactions occurred in 11.3% of the subjects. However, the increase was not significantly greater than 1.4 at 1 year for any of the serotypes or the aggregate. Therefore, it was concluded that revaccination in frail chronic ill older nursing facility residents was associated with a significant, albeit brief, immunological response and was well tolerated.

Effectiveness of a Multifaceted Intervention on Falls in Nursing Home Residents (JAGS 51:306-313, 2003)

This study was to evaluate the effectiveness of a multifaceted, non-pharmaceutical intervention on incidence of falls and fallers. With the design of prospective, cluster-randomized, controlled 12-month trial, it recruited 981 long stay residents aged 60 and older in six community nursing homes in Germany. The intervention included staff and resident education on fall prevention, advice on environmental adaptations, progressive balance and resistance training and hip protectors. The relative risk reduction was 0.45 to the incidence density rate of falls per 1000 residence years and 0.44 to the incidence density rate of frequent fallers. The results were statistically significant but the power is not enough to demonstrate a significant difference of hip or non-hip fractures.

SIG in Falls - report of second meeting

(We have the 2nd Fall SIG sharing meeting on 8/4/03 at Lai King Building, PMH
(Presence: Ko CF, Kong TK, Mok CK, Wu YM)

Falls in wards:

- Mok CK shared the review of fall cases in acute M&G wards in TMH for 02/03.
- Also shared the updated fall rates of HA hospitals up to 3Q02 - low fall rate c.f. the literature noted (better performance, more restrainers or under-reporting ??) and two local papers, UCH and QMH, on fall rates in hospitals.
- Fall prevention in acute wards discussed - no definite evidence of benefit according to latest literature review (Oliver 2000); local reports of success (HA convention papers - Kong TK may provide later) only; literature review- little benefits in RCTs, more benefits shown in less well designed observational studies.
- Experience of using sensor alarms, patient labelling etc. shared - no obvious benefits
- Use of screening scales (Morse, Stratefy) prevalent but only the step one of good intervention - need administrative support from high level
- For further study, consider multi-centre ones with one hospital as control, the other as intervention: prevent Hawthorne effect.

Enhance fall awareness at A&E:

- Suggest to introduce the guidelines for GP's to A&E colleagues; refer elders of first fall to multidisciplinary assessment

Fall clinics:

- The service is affected by the SARS situation in many units
- Difficult to set up a model format of operation as different units may have different expertise and focus
- May be worthwhile to do a survey
- Suggest to keep a good FU record of those patients using hip protectors

Next meeting: 8/7/03 (Tue)

Inter-hospital Geriatrics Meeting (03-04) 6:00 pm - 8:00 pm

(Amended 09/05/03)

Date	Topic	Venue	Organiser
25.04.03	Cancelled due to SARS		
30.05.03	SARS in Elders	HAHO 205S	Dr. Kong TK
27.06.03	Cancelled		
25.07.03	Pending (PMH) Sleep Disorders in the Elderly (YCH)	HAHO Seminar Rm 1	Dr. Kong TK Dr. Mo KK
22.08.03	Telegeriatrics - a controlled trial (RH) Pending (CMC)	HAHO 205S	Dr. Wong CP Dr. Ip CY
26.09.03	Rehabilitation of Elderly with Arthritis (PYNEH) Pending (AHNH)	HAHO 205S	Dr. Chan YP Dr. Ko PS
24.10.03	Pending (HOH) Pending (FYKH)	HAHO 205S	Dr. Leung MF Dr. Chan HW
28.11.03	Cardiac Rehabilitation in Older Adult Patients (KWH) The Clinical Manifestation of Vit B12 deficiency in Elderly (TPH)	HAHO Seminar Rm 1	Dr. Chan MH/ Dr. Miu KY Prof. Kwok CY
19.12.03	Pending (WCCH) Pending (UCH)	HAHO 205S	Dr Kong MH Dr Leung MF

Police force of the Wong Tai Sin district recruited about 400 elderly volunteer to be **"anti-crime elders"**. There were many con-tricks and scams being practiced by criminals in HK and elders were frequently victims of these scams. These volunteers had received training from the police force and their main duty was to let other elders know the tricks of the scams and to avoid to be the victim. **(The Sun 3/2/2003)**

Local News

After 30 years, those aged 65 and above will be about 2 million in Hong Kong (about **24% of the total HK population)**. Birth rate and also immigration rate to other countries were on the low side. **(The Sun 3/2/2003)**

Elderly need to **wait on average about 31 months for an infirmary place**, over 5200 elderly waiting for the 1134 infirmary places. During the 3 years from April 98 to March 01, over 7000 elderly died while waiting for the infirmary placement. **(The Sun 20/2/2003)**

A unit with a zero fall rate would clearly be rehabilitating no patients.

Oliver D et al. Do hospital fall prevention programs work? A systematic review. JAGS 2000; 48:1679-1689

An elderly home in Shatin area has 3 cases of **SARS**. The first case was an 86 years old lady who had symptoms on 24/3/2003. The other 2 cases were all roommates of the first case. All 3 cases had got fever symptom. **(The Sun 12/4/2003)**

Elderly and especially those are demented were easy to lost their way, **"FreeWalker"** is a mobile communications and safety service designed to fit into the lifestyle of elderly people. With its location-tracking features, it ensures people to know where the elders are at all times. **(Apple Daily 24/2/2003)**

Hong Kong Geriatrics Society - Membership application / Information update Form

A). Personal information for *membership application or information update*

Name	
Corresponding Address	
Current Practice (HA - Hospital Authority/ DH - Department of Health / PR - Private practice / HS - Hospital Service Department / HK - HKU / CU- CUHK / OT - Others)	"√" one of the following : ☐HA ☐DH ☐PR ☐HS ☐HK ☐CU ☐OT
Present post (e.g. MO, Cons, Prof. etc.)	
Hospital (working at)	
Department (working at)	
Home Address	
E - mail address	
Home Telephone	
Office Telephone	
Fax Number	
Basic Qualification (basic degree) and year	
Higher Qualifications and year	
Membership status to apply for or change	Please "√" either one below

☐ a) I am an accredited **Geriatric Specialist** according to the criteria of HK Academy of Medicine
☐ b) I am currently under **higher specialty training in Geriatric Medicine** according to HKAM
☐ c) I am a registrable medical practitioner in HK who is interested in Geriatric Medicine but the above two conditions do not apply.

Membership: (Official Use)	**Regular/Associate**
Approved by council at: (Official Use)	

* *Category a or b (Annual fee : $200) - Regular member*
Category c (Annual fee: $100) - Associate member (No voting right nor right to be elected as council member)
** For new application of membership, one has to be proposed by a **Regular Member** of the Society:

Name of Proposer: _____(Signature: _____)

B). I have the following publication/presentation of local studies / surveys in Geriatrics:

Title (Summary can be sent separately)	Journal index/ Name of meeting or seminar & dates

Please send this form to the following:

Dr. Mo Ka Keung Loar
Honorary Secretary, c/o Department of Medicine, Yan Chai Hospital, 7-11 Yan Chai Street, Tsuen Wan, New Territories, Hong Kong

✂ ..... ✂ ..... ✂

C). **Annual Fee for 2002/2003**
Please send a cheque payable to "The Hong Kong Geriatrics Society"
(Regular member: $200 - 1yr; Associate member: $100)

**Please tick if your want a receipt ☐ & your address:_____

Name :_____ Signature:_____ Date :_____

E-mail address: _____

Please send to : **Dr. Wong Tak Cheung, Honorary Treasurer, Hong Kong Geriatrics Society,**
c/o Dept. of Medicine, 1/F, Tseung Kwan O Hosp., 2 Po Ning Lane, Tseung Kwan O