Contents
P2  Announcement on Annual Scientific Meeting of HKSPM
P4  Report on The 10th Hong Kong Palliative Care Symposium
P10  The 10th Hong Kong Palliative Care Symposium Workshops
P12  Free paper abstracts from the 10th Hong Kong Palliative Care Symposium
P18  Report on the 13th World Congress of the European Association of Palliative Care in Prague and a visit to St. Joseph’s Hospice in Rajhrad
P21  Ethical Issues in End-of-Life Care in the Intensive Care Setting
P24  Reflection on Palliative Care for Advanced Cancer in the Age of Targeted Therapy
P26  Hypoglycaemia in advanced cancer patients
P29  Animal-assisted activity and animal-assisted therapy in palliative care
P31  Editor’s Column
P32  “Doctor, I don’t want to live” – suicide in cancer patients
P35  Membership Information
P37  Education Seminars & Meetings
P39  News from Society for the Promotion of Hospice Care

http://www.hkspm.com.hk
HA Commissioned Training Program
CUM Annual Scientific Meeting of Hong Kong Society of Palliative Medicine

IMPROVING BREATHLESSNESS IN
ADVANCED CARDIORESPIRATORY DISEASE AND CANCER

Speaker:
Dr Sara Booth,
Associate Lecturer, University of Cambridge and
Honorary Consultant, Addenbrookes Palliative Care Service,
Cambridge University Hospitals, NHS Foundation Trust

Organizers
Hong Kong Society of Palliative Medicine
Central Committee in Palliative Care
Hospital Authority

Co-organizer
Hong Kong Palliative Nursing Association

All are welcome!
No registration required
CNE CME Applied

Date: 29 November 2013
Time: 6:00 PM AGM of HKSPM
6:30 PM Lecture
Venue: Lecture Hall, M/F, HA Building

Sponsors
The 10th Hong Kong Palliative Care Symposium was held on August 10, 2013. This year, the venue was changed to the newly completed landmark building, the Centennial Campus, the University of Hong Kong. The symposium was held in the Lecture Hall II, Lee Shau Kee Lecture Centre and this gave participants an opportunity to visit this important new building.

This year we have attracted more than 350 participants from various sectors, professional fields and university. The big hall was filled with familiar and new faces, and among them, many have been supporting the event unfailingly in the past decade.
Dr. Ko Wing Man, honorable guests, representatives from supporting organisations and members of the Organising Committee

From left to right: Prof Cecilia Chan, Dr. Ko Wing Man and Dr. Chan Kin Sang

Dr. WM Ko, Prof Cecilia Chan and volunteers at the Symposium

Report on 10th Hong Kong Palliative Care Symposium
The morning sessions were then started by Dr. KS Chan who took us through the development of palliative care in Hong Kong from a physician’s perspective. This was followed by Ms. Ellen Yeung’s talk on the evolving role of the palliative specialist nurse. Both of the talks showed the audience the effort our pioneers took in promoting and establishing palliative care that we see today.

In the latter part of the morning session, Dr. Doris Tse then talked about the need of palliative care in acute care setting. She brought out the issue that provision of palliative care hospital consultative service lags behind other modalities and the need for palliative care of patients in acute hospitals, especially for non-cancer diagnosis, should not be ignored. The last morning session was delivered by Prof. Samuel Ho who discussed how different attachment styles and continuing bonds...
might affect post-bereavement adjustments among Hong Kong Chinese. He introduced two assessment tools, the Chinese Relationship Style Questionnaire and the Chinese Continuing Bond Scales, which were used to assess attachment styles and continuing bond.

Both morning sessions aroused intense interest among the participants as shown by their eagerness to ask questions and express their views. The morning was concluded by an interactive Q&A session before people departed for lunch or continue to join the lunch sharing sessions.
There were two activities during lunch with a photo tour to palliative care facilities in various countries conducted by Ms. Ellen Yeung and sharing of experience after attending the 35th Association for Death Education and Counseling annual conference by Ms. Carol Cheng. Lunch boxes were provided and participants had ample opportunity to interact and discuss.

Ms Carol Cheng from SPHC

In the afternoon, there were three concurrent sessions/workshops. In a workshop on “Pet bereavement experiences and its pilot interventions in Hong Kong”, Mr. POON Wing-Lok and Dr. Paul WONG shared with the audience preliminary findings of their on-going qualitative study exploring pet bereavement experiences in Hong Kong. (More on page 10)

Mr Poon Wing Lok, Dr. Paul Wong and their team at the Pet Bereavement Workshop

In another workshop conducted by Prof. Cecilia Chan titled “Caring for the carers: A body-mind-spirit approach towards professional wellness”, she introduced the concept and practice of Integrative Body-Mind-Spirit (IBMS) aiming to enhance holistic wellness of palliative health care workers. The audience was shown scientific support of its efficacy and had the chance to share concrete self-care and hands-on techniques. (More on page 11)
The third session was the free paper presentation. As in previous years, many high quality free papers were submitted. Apart from poster presentation, eleven papers were chosen for oral presentation. Judges for this session were Ms. Chan Lai Ngor, Dr. Wong Kam Hung and Dr. Rico Liu. There were two attractive prizes this year and congratulations went to the two winners Dr. Woo Kam Wing from Caritas Medical Centre and Dr. Yau Wai Shan from Buddhist Hospital.
Pet Bereavement Experiences and its Pilot Interventions in Hong Kong

Mr. POON Wing-Lok and Dr. Paul WONG
Social Work and Social Administration Department
The University of Hong Kong

Mr. POON Wing Lok, MSW, RSW, B. Comm., certified pet loss counselor

The number of households keeping pets has kept increasing in Hong Kong. According to the C&S, there was about a 19% increase of households keeping dogs and cats from 2006 to 2011. Most of the animal lovers treat their pets as companion animals or close family members like children, especially after experiencing the unconditional and pure love, companionship and loyalty of their beloved animals. Thus, the grief experienced of losing a companion animal could be intense and may lead to other psychological issues. Yet, the pet bereavement and close human-animal bond is often disenfranchised (ignored or underestimated) in our society. More, this type of bereavement can be complicated by issues like guilty and isolated feelings related to euthanasia decision, incongruence perspectives between family members and lack of appropriate platforms for emotional release.

In this workshop, we will share some preliminary findings of our on-going qualitative study which aims to explore pet bereavement experiences in Hong Kong. Animal lovers with pet loss experiences will be invited to share their grief and coping experiences. Also, the first-hand experiences of experimenting pilot pet bereavement interventions including support groups, talks, memorial, individual counseling and volunteering will be shared in this workshop.
Palliative healthcare work is a human-oriented and labor-intensive occupation, which places much emphasis on the professional values and missions to help people in need. In their daily job to accompany clients and their families through their suffering, palliative healthcare workers are prone to job related stressors, workplace violence, compassionate fatigue and burnout. Emotional exhaustion and disengagement, depersonalization, diminishing personal competence, and even psychological morbidity such as anxiety and depression are often resulted, leading to detrimental effects on physical and psychological well being, and passion and commitment at work.

This integrative body-mind-spirit (IBMS) workshop aims to enhance holistic wellness of palliative health care workers. It calls a holistic orientation emphasizes on physical, psychosocial and spiritual care; and integrates traditional Chinese philosophies, traditional Chinese medicine, and western therapeutic approaches. With the four core themes of relax, recharge, resolve and redefine, the workshop adopts a variety of body-mind-spirit techniques including physical exercise, expressive art, self-reflection exercises, and meditation to facilitate palliative healthcare workers in developing self awareness and stress reduction skills, cultivating self care practices, and re-defining passion and commitment at work. Over the years, the efficacy of this integrative approach in enhancing well-being has been supported by rigorous research studies in both clinical and non-clinical settings. Research evidence even suggested that the IBMS workshop for healthcare workers was effective in boosting forgiveness, fostering empathic attitudes, reducing negative attitudes towards clients, reducing stress, bolstering sense of mission at work and reducing job burnout. This experiential workshop will share concrete self-care and hands-on techniques for health care professionals.
Free Paper 1
To study the self-perceived burden (SPB) among advanced cancer patients and its clinical correlates in a local palliative care unit

YAU W. S.*
*Dr. YAU Wai Shan, Resident, Department of Medicine, Hong Kong Buddhist Hospital

Objective
To measure the prevalence and level of SPB and investigate the correlation between SPB and different factors in advanced cancer patients under the care of a local palliative care unit in Hong Kong.

Method
This was a cross-sectional study conducted from Feb 2012 to June 2012 in the palliative care unit of Caritas Medical Centre. The level of SPB was examined by Self-Perceived Burden Scale (SPBS). Demographic data and clinical characteristics were assessed. Variable factors, including functional status, physical symptoms, perceived social support, psychological symptoms, coping strategies, patient’s will to live and desire to hasten death were investigated for correlation with SPB.

Result
Among the 84 patients studied, the mean SPBS score (Standard deviation) was 29.1 (8.7), with 24 patients (28.6%) reported moderate SPB and 29 patients (34.5%) reported severe SPB. By Spearman’s correlation, there was statistical significant correlations between SPB and drowsiness ($r_s = 0.275, p = 0.011$), affectionate support subscale of Medical Outcomes Study - Social Support Survey ($r_s = 0.345, p = 0.001$), avoidance coping strategy ($r_s = 0.280, p = 0.010$), anxiety subscale of Hospital and Anxiety Depression Scale ($r_s = 0.223, p = 0.041$) and desire to hasten death ($r_s = 0.265, p = 0.015$). Functional dependency and depression, postulated to be relevant to SPB, were not identified to have significant correlation in our study.

Conclusion
Over two-thirds of our advanced cancer patients had moderate to severe sense of burden. SPB was found to be correlated with financial status, drowsiness, perceived good affectionate support, avoidance coping strategy, anxiety and desire to hasten death.

Free Paper 2
The Transformation of Filial Piety and its Effect on End-of-Life Family Caregiving in Hong Kong: Lived Experience of Chinese Adult Children Caregivers

HO A.H.Y. *, CHAN C.L.W., TAM M.Y.J.
*Mr. HO Andy H.Y., Research Officer & Honorary Lecturer, Centre on Behavioral Health, The University of Hong Kong

Background
The promotion of ‘filial responsibility’ combined with ‘aging in place’ policies has become the impetus that drives the coordination of elderly services in Hong Kong. This essentially places family, especially adult-children, at the forefront of end-of-life care for older terminally ill patients. However, a number of studies have indicated a declining adherence to filial beliefs and commitments among younger generations, of which may reflect vast dissonance between government policies that are based upon traditional values and the social realities of family practices.

Objective
This paper critically examines the evolving nature of filial piety and the role that it plays in the contemporary experience of ‘living and dying with dignity’ among Hong Kong Chinese families facing the end-of-life.

Method
Meaning-oriented interviews were conducted with a purposive sample of 15 adult-children caregivers, aged 30 to 62, to elicit their narratives and stories in caring for a dying elderly parent.

Result
Qualitative content analysis reveal that although traditional filial beliefs provided motivation for family caregiving, the regrets of unfulfilled filial responsibilities create emotional distance between parents and adult-children, which act as a cultural barrier for reconciliation and contentment at life’s final margin.

Conclusion
These findings underscore the importance of intergenerational dynamics and interactions in the transformation of filial attitudes and behaviors, highlighting the importance of reciprocal relationships (vs. authority relationship), mutual support (vs. complete obedience), compassionate duty (vs. obligatory duty), emotional connections (vs. task fulfillment), and appreciation and forgiveness (vs. guilt and shame) in the promotion of dignity in end-of-life caregiving. Policy and clinical implications are discussed.
Free Paper 3
Nurses’ perception on use of End-of-life (EOL) care plan as a framework to guide nursing care for dying patients and their families

NG J.H.K.*, LEUNG W., TSE DMW.

*Mr. NG Jeff Ho Kwong, APN, Dept. of Medicine and Geriatrics, Caritas Medical Centre

Background
A special care plan was implemented in eight medical and geriatrics (M&G) wards and the palliative care ward in Caritas Medical Centre since March 2013. A total of 114 nurses attended the training sessions before implementation.

Objective
To evaluate the perception of nurses on the use of special care plan in EOL care.

Method
M&G nurses were surveyed by a 20-item self-reporting questionnaire after a period of 3-month implementation. Descriptive statistics was used for statistical analysis.

Result
A total of 185 questionnaires were completed and returned (response rate 88.5%), among which 69.8% (n=125) had attended the training sessions while 82.7% (n=153) had used the special care plan.

Most of the nurses (n=142, 92.1%) agreed that the care plan provided guidance on EOL care, while 126 nurses (81.8%) stated that the care plan increased their awareness on care of the dying. Among all nurses, 123 nurses (79.8%) felt competent, including all nurses who worked in palliative care unit; 119 nurses (77.3%) had increased job satisfaction in caring for the dying; 126 nurses (81.8%) agreed that the care plan was beneficial to patients and relatives. Among the 65 senior nurses (>10 years’ experience), 67.7% of them found the care plan simple and easy to use, while 13 of 20 enrolled nurses (56.5%) felt it was complicated. Nurses from both acute and rehabilitation settings agreed that documentation of cares in the care plan was clear (87.8% and 82.15% respectively).

Conclusion
In conclusion, the special EOL care plan as a framework enhanced nurses’ job satisfaction and competence in EOL care. Though the majority found the care plan simple and easy, training on appropriate EOL care would further enhance quality of EOL care in non-palliative care settings.

Free Paper 4
Addressing patients’ and caregivers’ psychological needs with a stepped-care model in palliative care unit

LUK B.T.C.*, CHO V.W.C., TSE E.Y.C., NG I.

*Miss LUK Betty Ting Chi, Clinical Psychologist, Caritas Medical Centre

Background
Enhancement of Psychosocial Support to Palliative Care Services is a new programme which aims to address the psychological needs of cancer patients and their caregivers in palliative care unit (PCU). To increase access to psychological services with efficient use of manpower and resources, a stepped-care model was adopted with clinical psychology assistants (CPAs) administering psychological screening (PS), and providing low-intensity interventions (LII) under supervision of clinical psychologists.

Objective
To investigate the levels of psychological distress among patients and caregivers in PCU with data from PS by CPAs. Factors associated with psychological distress, as well as the implementation of stepped-care model were also explored.

Method
PS was conducted at PCU of Caritas Medical Centre and Our Lady of Maryknoll Hospital, in both hospital wards and out-patient clinics. Standardized questionnaires examining level of psychological distress were used, including Psychological Well-being Scale-Patients (PWS-P) for patients and Psychological Well-being Scale-Caregivers (PWS-C) for caregivers. Hospital Anxiety and Depression Scale (HADS) or 15-item Geriatric Depression Scale (GDS-15) was also administered, depending on the respondents’ age and literacy. Scores of patients and caregivers who had completed PS between April 2012 and March 2013 were examined.

Result
Results of multivariate ANOVA and t-tests revealed significant differences between the levels of psychological distress between hospitalized and non-hospitalized patients and their caregivers, with in-patients and their caregivers exhibiting higher levels of psychological distress.

Conclusion
Stepped-care model with CPAs conducting PS and LII was suggested to be an efficient use of resources for increasing access to psychological service and addressing the needs of patients and caregivers in PCU.
Free Paper 5
The preferred place of care and death in advanced cancer patients under palliative care services


Dr. WOO Kam Wing, Resident Specialist, Palliative Care Unit, Department of Medicine, Geriatrics and Intensive Care Unit, Caritas Medical Centre

Background
Facilitating advanced cancer patients to receive care and die in their preferred place is one of the main goals of palliative care. However, local data on patients’ preferences are limited.

Objective
To identify the preference and factors associated with preferred place of care (PPC) and death (PPD) among advanced cancer patients receiving palliative care.

Method
Patients’ preferred place of care and death, demographics, medical characteristics were collected and symptoms were assessed by Edmonton Symptom Assessment System (ESAS). A 17-item questionnaire was used to explore patients’ considerations regarding their preferred place of care and death.

Result
A total of 102 patients completed the study. The PPC concurred with PPD in 76.4% of patients. The most preferred PPC and PPD was palliative care unit (PCU) which accounted for 42.2% and 53.9% respectively; whereas home accounted for only 22.5% and 12.7% respectively. Five social and medical characteristics were significantly associated with both PPC and PPD, including age group, living with children or not, place of abode, ever admitted to PCU and presence of tiredness (p<0.05). The most agreed items in the 17-item questionnaire were different among various choices of PPC and PPD.

Conclusion
PCU was the most preferred place of care and death in our study. Associated characteristics and considerations for preferred place of care and death shed light on their strength and gaps. Further studies are warranted to explore the actual place of care and death in defining the unmet needs.

Free Paper 6

CHU W.W.C.*, THORSEN A, CHAN M.W.M., LAM C.Y.T.

*Dr CHU Wengent Wai Ching, Medical Officer, Haven of Hope Christian Service & Community Geriatric Assessment Team

In collaboration with Haven of Hope Hospital’s Palliative Care Consultation Service and Community Geriatric Assessment Team (CGAT), Haven of Hope Nursing Home, a 250-bed care home, has pioneered the End-of-Life (EOL) care service in 2000 (Chu et al, 2002; Chu et al 2004). Since then, eighty-nine residents have been taken care of and passed away in the nursing home under this EOL service. In addition to caring for the residents and their family members, “growth” in both service users and providers were observed through the care process (Chu et al 2011). Recent study has shown that 35% cognitive-sound nursing home residents prefer to die in their nursing homes (Chu et al, 2011). Chinese adults living in nursing homes are willing to pay an additional fee for community EOL care services in nursing homes (Chu et al, 2013). It is anticipated that good EOL care provision in residential settings will have an escalating demand in the ageing population with increased frailty and disability (Chu et al at 2011, Leung & Chong, 2010, Luk et al, 2011).

In this presentation, the experience on 13-year EOL care service in nursing home will be shared. To provide such care, sound clinical judgment with humanistic approach in a community context is essential. In particular, the essence on “Health and Social Integration” for the care provision is shared, namely, 1) mindset and knowledge, 2) partnership with other clinical specialties in a residential setting, 3) carer support.

Conclusion
End-of-life care for elderly people in Hong Kong has slowly shifted from hospitals to the long-term care sector and this trend is likely to continue. A well-coordinated health and social integration in EOL care provision in the community will see great benefit in the ageing population.
Free Paper 7
Development of a non-pharmacological based Chinese acupoints fatigue management programme for patients with advanced chronic illness


Mr. WONG Chun Ho, Physiotherapist I, Tuen Mun Hospital

Background
Fatigue is one of the commonest symptoms encountered by patients with advanced chronic illnesses. It affects patients’ mobility, exhausts patients, reduces social interactions and induces depressed and/or anxious mood. Chinese acupoints provide relaxation, stimulate balance of life energy, promote health and improve circulation around the body to reduce fatigue.

Objective
To evaluate the Chinese acupoints fatigue management programme.

Method
All patients were referred from medical palliative medicine (MPM) clinic, Tuen Mun Hospital. Patients with advanced chronic illnesses including advanced pulmonary disease, heart failure, renal failure and motor neuron disease were enrolled. Patients and carers received specific Chinese acupoints management including thermal therapy over points and carer empowerment training. Pre- & post-assessment was conducted for evaluation of level of tiredness, self-efficacy and functional level by palliative performance scale (PPS). The comments from patients and carers about this programme were also collected.

Result
A total of 30 patients and 32 carers were enrolled with 186 attendances from Jan 2012 to May 2013. Patients’ tiredness level was significantly reduced from 4±1 to 1±1 (p<0.05). Self-efficacy level significantly improved from 2±0 to 4±1 (p=0.001). PPS improved from 30±4 to 50±15 (p=0.007). Carers’ tiredness level was significantly reduced from 4±1 to 1±1 (p<0.04) also. Comments on this programme by patients and families were positive: “I feel better! And, I can enjoy the precious moment with my family”; “I feel less weak! I can walk and move as I wish now.”; “We never think we can cope with fatigue in advanced illness before. But now we can!”

Conclusion
Patients and carers were more confident in coping with the illness. Fatigue symptom of our patients was alleviated with this programme.

Free Paper 8
An exploratory study of the palliative care needs of patients with advanced heart failure and their family caregivers in Hong Kong

CHAN H.Y.L.*, YU D., LEUNG D., LEE I, LOW L., LEE D., HUI E.

*Dr. CHAN Helen Yue Lai, Assistant Professor, The Nethersole School of Nursing, The Chinese University of Hong Kong

Background
Heart failure (HF) is a clinical syndrome resulted from various cardiac conditions, with a mortality rate up to nearly 70% within 5 years of diagnosis. Hence, there has been a growing awareness towards the needs of patients with advanced HF.

Objective
This study aimed to identify the palliative care needs of patients with advanced HF and their caregivers, by relating the caregiving experience to the patients’ illness presentation.

Method
A total of 35 patients with advanced HF and their primary caregivers were recruited from a hospital setting. The patient-caregiver dyads were interviewed by questionnaires and open-ended questions. Data triangulation was done to relate the caregiving experience to the patients’ disease burden.

Result
By using Palliative Performance Scale, McQill Quality of Life Questionnaire, Caregiver Strain Index and Hospital Anxiety and Depression Score, the finding indicated that the patients were characterized with poorly-controlled symptoms, high level of disability and poor quality of life. This resulted in a high level of caregiving burden and psychological distress among the caregivers. The caregivers paid unfailing efforts in taking care of the patients. Yet, witnessing progressive disease deterioration was inevitable and caused the most frustration. They were also exhausted in dealing with the patients’ uncooperative behaviours in disease management.

Conclusion
This study suggested that promoting palliative care is a highly prioritized agenda for patients with advanced HF. It also revealed an important service gap in empowering caregivers of patients with advanced HF in understanding the disease trajectory and adopting palliative care approach in managing this disease at the advanced stage.
Free Paper 9
What is the attitude of older residents toward euthanasia?

LAW P.K.N.*, CHAN W.H.C.

* Ms. LAW Noble Po Ka, Professional Consultant, The Nethersole School of Nursing, The Chinese University of Hong Kong

Background
Older people living in residential care homes (RCHEs) have multiple co-morbidities and significant mortality. Understanding older people’s attitude toward euthanasia is imperative to provide quality end of life care.

Objective
To examine the preference of euthanasia and the independent predictors among older people living in RCHEs

Method
A cross-sectional quantitative study by face-to-face interview with a structured questionnaire was used. Whether the older residents wished to have euthanasia if they were severely ill with no hope of recovery was examined. Factors with a p-value <0.25 in univariate analyses were selected for multivariable logistic regression to delineate factors independently associated with the outcome.

Result
A total of 317 residents (248 women and 69 men) aged 65 to 99 (mean±SD) 84±6.6 were recruited. Nearly 70% of respondents agreed to the statement that they would like to have a drug at their disposal to end their life when they chose to, if they were severely ill with no hope of recovery. Those having lived longer in residential care homes were less likely to agree with this statement. Those with perceived mobility problems were more agreeable to euthanasia.

Conclusion
The finding revealed that a significant proportion of older residents agreed with euthanasia. In response to older people’s wish, open discussion involving older people among the society is recommended. Further investigation is also warranted.

Free Paper 10
Care Received by Patients with Advanced Dementia in their Final Days of Life


*Dr. CHEUNG Wai Yin, Resident Specialist, United Christian Hospital

Background
Patients with advanced dementia in Hong Kong are usually hospitalized in their final days of life.

Objective
To study the care received by these patients during their last hospitalizations.

Method
All deaths of patients aged 65 or older in the geriatric wards of UCH from 1 September 2010 to 30 June 2011 were generated from electronic database. Those with a diagnosis of advanced dementia (FAST 7c or above, and equivalent) of any aetiology were subjected to retrospective review.

Result
A total of 173 patients with mean age of 86.8 (SD 7.2) were reviewed, and 92% were nursing homes residents. Pneumonia accounted for 76% of admissions, followed by sepsicaemia (25%) and cardiovascular events (19%). Parenteral fluid, oxygen and antibiotics were prescribed in 95%, 89% and 80% respectively. Inotropes, ventilatory support (invasive or non-invasive) and initiation of tube feeding were given in 14%, 10% and 8% respectively. Sixteen percent of patients had cardiopulmonary resuscitation performed. The median time of first-ever Do-Not-Resuscitate order issued was 4 days before death (inter-quartile percentiles 1-23.5). Dyspnoea (56%) was the commonest documented symptom, followed by delirium (27%) and anorexia (12%). Analgesics, tranquilizers and antisecretory agents were prescribed in 28%, 1.8% and 2.3% respectively, while 41% had their unnecessary medications discontinued. Palliative care specialists and bereavement care professionals were involved in 1.7%.

Conclusion
An acute medical model of care was adopted for patients with advanced dementia during their final days. Decision on DNR was made when deaths were imminent. Measures for symptom control and psychological support for bereaved families were inadequate. Education on holistic EOL care should be promulgated.
Enhancing Emotional Competence of Healthcare Professionals in Supporting Patients Experiencing Perinatal Loss: A Programme Evaluation Study

Miss TSUI Elaine Yin Ling, PhD Candidate, Department of Social Work and Social Administration, The University of Hong Kong

Background
About one in five pregnancies resulted in miscarriage and the number of miscarriage or abortion in the first trimester in Hong Kong was 7,272 in 2004. Pregnancy loss is marked by its ambiguous nature. Adequate perinatal bereavement support would be important to help individuals or couples to overcome their grieving process. Among various departments in the hospital, Obstetrics and Gynecology (OB/GYN) is expected to be a place of joy and happiness in welcoming babies; it is therefore even more challenging for OB/GYN colleagues to support bereaved individual/couples in saying goodbye to their beloved babies. Some colleagues shared that they might experience psychological distress when they were helping in the delivery process, especially for couples who were delivering stillborn babies.

Objective
The core objective of the training workshop aimed to increase the knowledge, attitude and practice of perinatal bereavement care among healthcare professionals and midwives. It is expected to enhance their emotional competence in facing death and dying.

Method
As supported by the HKU Knowledge Exchange Fund, a series of professional training programme on perinatal bereavement counseling has been conducted since April 2013. The core objective of the programme aimed to increase the knowledge, skills, as well as the emotional competence among healthcare professionals in working with perinatal loss. Professional Quality of Life and level of competence (including level of confidence and comfortability in dealing with patients with pregnancy loss) were measured prior and immediate after the training, which are served as the indicators of the outcome evaluation.

Result
Seventy-six healthcare professionals, with the mean age of 42.1±9.7 and average year of experience in obstetric and gynecology at 10.7±9.6, took part in the two-day professional training. Participants demonstrated an overall improvement on the level of confidence, t(52)=-7.663, p<0.001, and level of comfortability, t(54)=-6.244, p<0.001. Further post hoc analysis suggested that, comparing with individuals reporting lower burnout score, those with higher burnout showed significant lower level of confidence at baseline measure, t(23) = 4.55, p<0.001, but achieved similar level of confidence after the training.

Conclusion
Results implied that the general emotional competence of healthcare professional in OB/GYN should not be overlooked, which could have significant effect on the quality of care ultimately.

See you next year !
Mission of the European Association of Palliative Care (EAPC) is to bring together many voices to forge a vision of excellence in palliative care that meets the needs of patients and their families and it strives to develop and promote palliative care in Europe through information, education and research using multi-professional collaboration, while engaging with stakeholders at all levels. I am happy to report that these values were fully reflected in the programs of the 13th annual meeting held in Prague, Czech Republic in May 2013. By deciding to attend this meeting, it gave me a chance to visit hospice in the region.
I wrote to the President of Czech Society for Palliative Medicine seeking for an opportunity to visit a hospice near Prague before attending the conference. My request was promptly accepted and I was invited to visit St. Joseph Hospice in Rajhra where the President, Dr. Kabela was the director. Rajhra, after some internet search, turned out to be 2 hours away by train and another 15 minutes by car. Luckily very clear transport instructions by his personal assistant and she picked me up after my train ride. The hospice used to be an army barrack but it's converted into a warm and caring 40 beds hospice. A chapel was recently created to enhance spiritual care for patients, their family members as well as staff.

It is interesting to see the development of palliative care in Czech Republic which bears some similarity to Hong Kong. Czech Republic has a population of 10.5 million with annual death rate of 105,000, of which 25% due to malignant disease, 50% of cardiovascular and cerebro-vascular disease with remaining 25% of respiratory disease. Multi-professional palliative care was first developed in 1989 and now there are 16 hospices with a total of 460 beds. Palliative care topics has been introduced to medical and nursing curricula and since 2004 palliative medicine has established as a sub-specialty under "Palliative Medicine and Pain Management".
To come back to the EAPC meeting, it ran from 30 May to 2 June and it started off with a good choice of workshops which required prior registration. Those popular ones were fully registered early but luckily they did allow others to join 15 minutes after commencement provided seat were available. I joined "The Role of Leadership in Palliative Care" conducted by Prof. Frank Ferris from the USA. He showed us how to lead a multidisciplinary team in decision making and issues such as a role and a position of a palliative care in a health system. I was particularly impressed by his teaching on communication skills. This was followed by "Improving the Multi-Professional Management of Cancer-Related Pain" which discussed topics on "Optimal pain control – why is it so hard to get it right?", "Understanding Breakthrough Pain", "Tools and techniques for improved assessment of Breakthrough Cancer Pain (BTCP)", "Approaches to the management of breakthrough pain' and "Practical guidance for the management of BTCP".

In the subsequent days, a comprehensive range of palliative care topics were presented in symposium format including "Pain Management in 2013", "Gastrointestinal Symptoms", "Spiritual Care", Leadership in Palliative Care: From Good to Great", "Implementing Palliative Care in Nursing Homes" and "Paediatrics ". There were also sessions on meeting the experts with topics like "Resilience in Palliative Care" and "Social Media in Palliative Care".

I attended a lunch film session showing two videos, one on music therapy and the other on bereavement. The room was jam packed with people sitting on chairs and floor as well as some standing. The video on music therapy showed how it was developed in one of the hospitals in Spain and the way it helped touch on the hearts of dying patients and their family members. It then showed "The Gifts Of Grief" which was a series of real life personal accounts of how they faced loss and how they came through it. For those who hasn't seen it, it's truly worthwhile watching.

In this conference, one could also join into different task force discussions such as "Task force on Paediatric Palliative care", "Task force on Integration of Oncology and Specialized Palliative Care", "Task force on Spiritual Care" and "Primary Palliative Care Task force".

Most of the attendance were Europeans but I managed to find familiar faces from Singapore, Malaysia and Australia. Overall, I find this meeting worth attending because of wild range of information, friendly format and often appealing location.

I did make some changes to my practice after this meeting in terms of involving spiritual workers into the multi-disciplinary team to enhance this aspect of care.
Introduction

The Consensus Statement by the American College of Critical Care Medicine (ACCM) on end-of-life care in the intensive care unit (ICU) in 2008 states that admission to ICU is “often a therapeutic trial”.\(^1\) Twenty two percent of all deaths in USA occur in ICU. As the trial fails, the goal of care changes from restorative to palliative, or “from cure to comfort”. However, this transition to and provision of end-of-life care in ICU is not easy. It is often difficult to predict prognosis accurately. Also, complex ethical issues are involved particularly in withholding and withdrawing life sustaining treatment, and in the use of symptomatic medications that may shorten life.

Withholding/withdrawing life-sustaining treatment

**General principles**

In order to assist clinical staff to handle the complex ethical issues, the Hospital Authority of Hong Kong issued her Guidelines on Life-Sustaining Treatment in the Terminally Ill in 2002.\(^2\) According to the Guidelines, life-sustaining treatment refers to “all treatments that have the potential to postpone the patient’s death”, examples include cardiopulmonary resuscitation, mechanical ventilation, dialysis, etc. The Guidelines consider that withholding and withdrawing life-sustaining treatment in appropriate situations is ethically and legally distinct from euthanasia and legally acceptable in most parts of the world including Hong Kong. It is appropriate to withhold or withdraw life-sustaining treatment when the treatment is against the wish of a mentally competent patient, or when the treatment is “futile”. The determination of futility other than “physiologic futility” involves balancing the burdens and benefits of the treatment towards the patient, and asking whether the treatment is in the best interests of the patient. The answers to what is to patient’s best interests often involves quality-of-life considerations in addition to medical consideration, and are therefore value-laden. The decision-making process in most cases is thus a consensus building process between the healthcare team and the patient and family.

The Consensus Statement of ACCM also emphasizes consensus building with the patient and the family in the decision.\(^1\) Below is a list of recommendations in the Consensus Statement:

- Patients and families must be given sufficient time to reach decisions.
- Information should be delivered in ways that are sensitive to the patient’s cultural, religious, and language needs.
- Physicians should take seriously their responsibility to make recommendations and guide families in ways that accord with their decision-making preferences.
- Merely providing treatment alternatives and asking patients and families to choose among them may make the patients and families feel solely responsible for the decision, and is not preferred.

Incompetent patients

According to the Consensus Statement of ACCM,\(^1\) treatment decisions for incompetent patients in USA, should be made by a surrogate based on “substituted judgment”, or if patient’s prior values and preferences are not known, based on “best interests”. Consensus building is often adopted in the decision-making process. The surrogate is either someone appointed by the patient previously or as defined by the legal hierarchy at the time of decision making. If there is no appropriate surrogate, ACCM recommends against ad hoc decision-making. One should either appoint a guardian or follow a clear procedural guideline.

The legal consideration in Hong Kong is slightly different from USA. Under the Mental Health Ordinance,\(^3\) a doctor may carry out medical treatment for a mentally incompetent patient without consent, if the treatment is necessary and in the best interests of the patient. A valid and applicable advance refusal of life-sustaining treatment has to be respected.\(^4\) However a proxy directive has no legal status in Hong Kong.

In common law, the best interests of a patient are not limited to the best medical interests but encompass medical, emotional and all other welfare issues. Thus, the prior wishes and values of an incompetent patient are important considerations. In general, the family members are in a better position to ascertain the prior wishes and values of the patient. Therefore, the decision-making in most cases is a consensus-building process between the healthcare team and the family.
Handing disagreements

To handle disagreements, there should be repeated communication to clarify misconceptions and to align values. Sometimes, it is useful to obtain a second opinion. If necessary, one may seek the view of the relevant ethics committee, or in rare situations, the judgment by the court.

Special problems in the acute care setting

In the acute care setting, compared to palliative care or geriatric care, there may be special problems in making a decision to withhold or withdraw life-sustaining treatment. The figure illustrates the potential difficulties facing the patient, the family and the clinician.

The clinician

- forgoing treatment may be perceived as a medical failure,
- there is apparent contradicting role of the medical profession,
- there may be lack of knowledge and experience on how to do this (especially communication skills),
- the clinician may impose his own value judgment to the case,
- the situation is complicated by resource limitation.

The family

- family members may not know the prior wishes of the patient,
- family members may have denial of the terminal condition and have unrealistic expectations on the outcome of treatment,
- family members may misunderstand that, to show filial piety, they should never forgo treatment for their loved ones.

The Patient

- too ill to participate meaningfully in the discussion
- not prepared to discuss end-of-life care.

There are no easy answers to the problems. Immediate approaches include good communication by adequately experienced staff with adequate time, team-based decision-making, and seeking independent second opinion if necessary. Longer term approaches include more education to the public, encouraging people to discuss with family members on one’s own end-of-life care, appropriate use of advance directives, and more education and training for clinicians.

The Consensus Statement of ACCM recommends strategies to improve communication with the family.1 These include:
- family conference early in ICU course,
- find a private location,
- “hoping for the best and planning for the worst”,
- spend more time listening to families, value the family input, and acknowledge and address their emotions,
- ongoing and direct communication concerning the patient’s prognosis,
- explore and focus on patient’s values and treatment preferences,
- affirm non-abandonment of patient and family.

It is useful to note one special recommendation from ACCM. Some families may choose to be present during resuscitation and other invasive procedures. ACCM considers that these experiences may be highly valued by family members and need not interfere with the delivery of medical care.
**Ethical Issues in End-of-Life Care in the Intensive Care Setting**

On the withdrawal of artificial ventilation, the HA Guidelines on Life-Sustaining Treatment in the Terminally Ill consider that there are no legal or necessary morally relevant differences between withdrawing and withholding life-sustaining treatments. However, there could be practical and emotional problems with withdrawal of artificial ventilation. The Consensus Statement of ACCM states that the withdrawal of life-sustaining treatments is not legally considered a killing, and the actions of clinicians in this regard are described as “allowing the patient to die” from the underlying illness.

On withholding cardiopulmonary resuscitation (CPR), if there is evidence that CPR is against the patient’s wish or against the patient’s best interests, one may make an elective decision whether to withhold CPR or not, through consensus building with patient/family, following the same ethical principles as withholding other life sustaining treatments. It is best to have clear procedural guidelines on this.

**Use of symptomatic medication that may shorten life**

Another ethical issue in end-of-life care in the acute setting is the use of symptomatic medication that may shorten life in the dying process. Proper use of analgesics in palliative care seldom shortens life. However, palliative sedation may shorten life, and there are ethical controversies on this. In general, palliative sedation could be ethically justified if it is reserved only as a last resort to dying patients with refractory symptoms, if the dose of the sedation given is to relieve the symptoms rather than to kill the patient, and if the decision is made after careful balance of the harm and benefits and after consideration of the patient’s choice.

Some ethicists use the principle of double effect in the discussion. This originates as a Roman Catholic principle. The classic formulation is as follows:

- The nature of the act must be good or neutral.
- The agent intends only the good effect. The bad effect is merely foreseen but not intended.
- The bad effect must not be a means to the good effect.
- The good effect must outweigh the bad effect (proportionality).

This doctrine is controversial, because it relies on an assessment of the intentions of the clinician which can be subjective. However, the Consensus Statement of ACCM raises that the intention can be evidenced by an ongoing assessment of the patient’s comfort, together with judicious titration of sedation and analgesia in accordance with clinical guidelines.

**Conclusion**

I would like to conclude by discussing the problem of a self-fulfilling prophecy. When the clinician explains to the family that the patient is dying, which is then followed by withholding or withdrawing a life-sustaining treatment, the patient will likely die. This is a self-fulfilling prophecy and does not necessarily support the appropriateness of the decision. This demonstrates the importance of a thorough assessment without unsuitable motives before making a decision, and the importance of consensus building, because some degree of uncertainty and value judgment is often involved. Finally, I would like to emphasize that, for a clinician to help a patient to attain a peaceful death, an appropriate attitude, appropriate knowledge and skill, and compassion towards the patient and human suffering are all important.

**References**

Reflection on Palliative Care for Advanced Cancer in the Age of Targeted Therapy

Dr. Rebecca Yeung
Department of Clinical Oncology
Pamela Youde Nethersole Eastern Hospital
Email: yeungmwr@ha.org.hk

(Presented in Multi-specialty Medical MEGA Conference 2013 on 13th April 2013 at Langham Place Hotel, Hong Kong)

Abstract
The new age of targeted therapy brings success and hope for cancer patients, but on the other hand poses challenges for palliative care. With more treatment options, the oncological treatment process becomes more protracted and complicated. Palliative care is more compressed towards the end of life and patients may find it more difficult in accepting death. Treatment decision has become more difficult and complex for both doctors and patients. Patients have their own unique experiences during the cancer journey, which will have important impact on their acceptance of disease and palliative care. Hence, palliative care has to be holistic, personalized, and targeted at the very unique underlying needs of the patient.

Introduction
Man’s health condition and life expectancy has been improving throughout human history. The biggest improvements occurred in the past two centuries and are mostly contributed by better sanitation and the use of antibiotics. It appears that the improvement has now reached plateau and any further gain will be of comparatively minute scale. Death remains the limit.

The situation in Hong Kong is similar to other countries. Cancer is the top killer which contributes to 30% of all deaths. Around half of all cancer patients will die of the disease.

Age of Targeted Therapy
Cancer treatment has now entered a new age during the past one to two decades - the “Age of Targeted Therapy”. It is not only about targeted therapy, but also other advancements, e.g. new surgical and radiotherapy techniques, more sophisticated investigations (e.g. PET scan), better screening programmes, etc.

New targeted therapies are of no doubt very powerful treatment weapons which bring revolutionary outcomes. Tumours that are resistant to treatment in the past may respond well, resulting in dramatic survival improvement as well as symptom relief.

Hence, the age of Targeted Therapy is also an age of Hope. Patients have high expectations about disease outcome. They may hope that the treatment can cure even the most resistant disease and further breakthrough can appear any time.

Changing landscape of life of cancer patients
In such an era, the life of cancer patients has changed greatly. In the past, treatment decision was simple. Patients with incurable cancer might just receive palliative care. Nowadays, anti-cancer drug treatment commonly becomes the first station patient will come to.

Life has now become more busy and complex for patients undergoing investigations, studying treatment options, making decisions and attending treatment sessions. As there may be multiple lines of treatment, this phase may occupy quite a long period of time. Also, since it is often easy to administer the targeted drugs especially in oral forms and they are of mild side effects, it is not uncommon that the treatment is still going on in terminal patients.

A double-edged sword
Is this new age a barrier or an opportunity to palliative care?

In fact, it is a double-edged sword.

These new treatments may improve the quality of palliative care since they may give better disease response and symptom relief. Survival may also be prolonged. Patient can thus take more time to accept their disease and prepare for their death.

On the other hand, there may be negative impact also. This may provide false hope for patients. Both patients and doctors may use this as an escape. Palliative care may be postponed or compressed to the very end. Also, targeted therapies are not without side effects. Patients may still suffer from the adverse reactions which impair their quality of life.

Moreover, targeted therapies are often expensive. Currently, majority of these are self-financed items in the Hospital Authority. They pose a great financial burden for patients and their families. Patients who cannot afford may have regret or grievance.

Reflection on Palliative Care for Advanced Cancer in the Age of Targeted Therapy

HKSPM Newsletter 2013 Oct Issue 2 P24-25
Reflections

Being an oncologist as well as a palliative care doctor, I would like to share some reflections on palliative care under this age.

1. More difficult tasks for doctors and patients

In primitive age, man would view life and death as part of nature, and it is easier for them to accept what life brings. In this modern age, however, we feel increasingly difficult to be at ease with life and death. We will struggle hard to fight for any minute gain in survival.

Besides, it is becoming more difficult for modern doctors to make treatment decisions. It needs great wisdom and courage to admit that there is no further active treatment available.

On the other hand, it is also becoming more difficult for patients to cope with different roles at different phases along the winding cancer journey: to accept the cancer diagnosis swiftly, engage in active treatment, stop treatment at the appropriate time, and to switch to palliative care. Ultimately, he/she has to accept death when the time comes, everything in a timely manner. Unfortunately, accomplishing each step and fulfilling what each role demands with perfect timing is just an ideal.

As patients may have individual needs and behave very differently from what we expect, doctors need to be more understanding, open and accommodating. When we accompany patients in their cancer journey, we have to be aware that it should be at their own pace and time schedule, but not ours. What is important is their wish and not ours.

2. Effectiveness of palliative care

While the targeted therapies are so powerful, we may wonder whether palliative care is becoming more limited and negligible. Fortunately, we now know that palliative care not only bring about symptom relief and improvement in quality of life, but also prolong survival1. Hence, though survival gain is not a primary aim in palliative care, it can be a realistic outcome. If use appropriately and well, palliative care has more benefit than we may expect.

3. The impact of cancer treatment experience

Patient’s experience and perception during the phase of active cancer treatment may have important impact on his acceptance of subsequent palliative care. If the patient thinks that he has already received the best possible treatment, then he will have less regret. He may then accept his terminal phase and palliative care better. On the other hand, if the cancer treatment journey is full of anger, regret and grievances, it will be more difficult for patients to have good acceptance.

Hence doctors managing patients during their earlier phase of cancer journey can contribute to palliative care indirectly by preparing patients for a more receptive ground towards palliative care.

4. The issue of hope

Targeted therapy brings hope, but sometimes also false hope. Doctors often find it difficult to handle patients who have false hope and choose to fight till they die. However, quality of life is to be defined by patients and not by us. For those fighters, any minute gain in life may be meaningful to them. One who finds meaning in fighting till he dies is as respectable as the one who accepts death peacefully. The core issue for us is how patient’s unrealistic hope could be accommodated in the treatment plan. We need to be more open and accommodating. On the other hand, patients have the ability to have personal growth. As time goes on, they may be able to transform their false hope into a more realistic positive momentum.

5. Healing as the ultimate goal.

Though targeted therapy can bring a period of improvement, the success is only transient. Deterioration and death is eventually unavoidable. At the end of the day, “Healing” is more important. For “Healing”, I mean the spiritual healing but not physical. Finding ways to help patients to achieve healing is a worthwhile goal for the whole palliative care team.

Conclusion

Palliative Care is not only a holistic but also a personalized treatment. It strikes the unique and individual target deep inside the patient. In this way, it is also one kind of targeted therapy.

Reference

Hypoglycaemia in advanced cancer patients

Dr. Yau Wai Shan, Cora
Department of Medicine, Hong Kong Buddhist Hospital
Correspondence: yws073@ha.org.hk

Abstract
Recurrent hypoglycaemia in advanced cancer patients is a common condition in palliative care setting. Non-Islet Cell Tumour Induced Hypoglycaemia (NICTH) is a rare but important condition as it is one of the possible treatable underlying causes of hypoglycaemia. This article would present two cases of recurrent hypoglycaemia in advanced cancer patients and discuss the pathophysiology, clinical symptoms, diagnosis and treatment of NICTH.

HKSPM Newsletter 2013 Oct Issue 2 P26-28

Introduction
Recurrent hypoglycaemia in advanced cancer patients is a common condition in palliative care setting. Hypoglycaemia can be fatal and associated with morbidity. It is very important to identify any underlying treatable causes. However, some of the causes are not reversible in advanced cancer patients. Symptomatic treatment, including long term oral or dextrose infusion, can be given to correct the hypoglycaemia. At the end-of-life care phase, intravenous dextrose infusion has some disadvantages as it is more invasive and inconvenient. It can create burden to patients and may have negative impact on the quality of life. The following cases illustrated the clinical issue of recurrent hypoglycaemia in two advanced cancer patients in palliative care setting.

Case 1
Mr. I, a 58-year-old gentleman, was diagnosed to have carcinoma of stomach with multiple liver metastases in March 2013. He presented with bilateral lower limb edema and hepatomegaly. Computed tomography (CT) of abdomen showed carcinoma of stomach with multiple liver metastases and possible nodal metastasis. Surgery was not feasible. He was treated with palliative chemotherapy using oxaliplatin and capectabine by oncologist in mid of May 2013.

He was admitted to medical department of Queen Elizabeth Hospital (QEH) in the end of May 2013 for collapse. On admission, he was found to have dehydration, hypotension and hypoglycaemia. He had deranged liver function with raised alkaline phosphatase and hypoalbuminaemia. His cortisol level and thyroid function were normal. He was treated with intravenous fluid, dextrose solution and antibiotics. His condition improved. Oncologist suggested stopping the palliative chemotherapy in view of deteriorating general condition and poor tolerance to chemotherapy. Pain control was satisfactory with tramadol and paracetamol. However, he had refractory hypoglycaemia and required continuous dextrose infusion. He was transferred to Palliative Care Unit (PCU) of Hong Kong Buddhist Hospital (HKBH) in mid of June 2013.

Because of the continuous intravenous infusion, Mr. I had become bed-ridden since hospitalization. He also needed repeated attempts for vascular access for intravenous infusion. What was the cause for the recurrent hypoglycaemia? It can be related to the poor liver reserve in view of liver infiltration by tumour. Another possible cause could be explained by the phenomenon of Non-Islet Cell Tumour Induced Hypoglycaemia (NICTH). Dexamethasone 4mg daily was prescribed and his blood glucose level increased in daytime. However, he still had occasional fasting hypoglycaemia despite an increment of dexamethasone to 4mg twice per day. Dextrose drip was given at night to avoid fasting hypoglycaemia. He was able to wean off intravenous infusion in daytime to allow ambulation. He could walk with mild assistance in ward and felt happy as he had some improvement in the functional status.

However, his condition gradually deteriorated after two months of hospitalization in PCU. He became more cachexic and he could not tolerate oral medications. Dexamethasone was stopped and dextrose infusion was continued. Patient and his wife were interviewed and they agreed not for further glucose monitoring at the terminal stage of illness if he became unconscious or we failed to obtain vascular access. In the final days of illness, he was in semi-conscious state and there was difficulty in setting intravenous access. Subcutaneous fluid was given and glucose monitoring was withheld. He finally succumbed peacefully one day after dextrose solution was stopped.

Case 2
Mrs. L, an 83-year-old lady, had known history of hepatitis B carrier and hypertension. She had total abdominal hysterectomy with bilateral salpingo-oopherectomy for fibroid and laproscopic cholecystectomy in the past. She first presented with collapse and hypoglycaemia in March 2013. Physical examination found that there was a mass over epigastrium. During the hypoglycaemic attack, her serum insulin level was suppressed to smaller than 1.0mIU/L (Reference range: 3.2-14.6mIU/L). Her cortisol level was normal. She was then diagnosed to have intra-abdominal myxofibrosarcoma with CT abdomen showing a large vascular tumour of size around 17 centimetre (cm) x 10 cm x 20 cm in the abdomen and upper pelvis. Ultrasound guided core biopsy revealed spindle cells and overall features were suggestive of malignant mesenchyma tumour, in favour of myxofibrosarcoma (myxoid malignant fibrous histiocytoma). Oncologist suggested that there was limited role of chemotherapy or radiotherapy and aimed for

Hypoglycaemia in advanced cancer patients
supportive care. Her blood glucose level was gradually normalized after she had frequent small meals.

However, she was admitted to medical department of QEH in July 2013 after fall induced by dizziness related to recurrent hypoglycaemia. On the day of admission, her capillary blood glucose level was only 2.2mmol/L. She also complained of decreased oral intake because of abdominal discomfort after meals. She was put on intravenous dextrose solution for treating hypoglycaemia. However, she required continuous intravenous dextrose infusion to maintain her glucose level. Furthermore, her condition was complicated with fracture of left ring finger after fall. She was put on splintage after orthopaedic surgeon’s assessment. Her blood result also showed hypokalaemia with serum potassium level of 2.6mmol/L (Reference range: 3.4-5.0mmol/L). Potassium supplement was given.

She was transferred to HKBH PCU for further management. She was fully alert. However, her mobility was limited as she required intravenous glucose infusion. In view of the histological origin of her tumour and previous documented suppressed insulin level, she was clinically suspected to have NICTH. She was treated with dexamethasone 4mg daily and her glucose level was corrected rapidly. Her dextrose drip was stopped as her glucose level was normalized after one day of treatment. Physiotherapy and occupational therapy was given. She could walk unaided and her Barthel Index was 80 out of 100. She would be discharged home with regular home care nurse visit and followed up in PCU out-patient clinic.

Discussion

Hypoglycaemia in cancer patients can be due to different underlying causes. The most common cause is induced by insulin or oral hypoglycaemic agents in patients suffering from underlying diabetes mellitus. During the course of illness, advanced cancer patients have gradual decrease in oral intake. Meanwhile, there is also increasing risk of development of renal failure due to various reasons. Therefore, diabetes mellitus patients with terminal illness are more prone to hypoglycaemic attack. In rare case, hypoglycaemia can be the initial presentation of neoplasm. Cancer patients with hypoglycaemic attack can be related to different factors and generally can be classified into three categories. Firstly, it is caused by tumours producing excess insulin e.g. pancreatic insulinomas or ectopic insulin-producing tumours. Secondly, there are tumour-related factors, such as destruction of the liver and adrenal glands by massive tumour infiltration. Thirdly, hypoglycaemia is rarely related to the production of substances interfering with glucose metabolism. The substances can be insulin receptor antibodies (e.g. in Hodgkin's disease and other haematological malignancies), cytokines (e.g. Tumour necrosis factor, interleukin-1 and interleukin-6), catecholamines (e.g. in phaeochromocytoma), secretion of insulin-like growth factor (IGF-I) and tumours that secrete partially processed precursors of IGF-II. The later condition is also known as Non-Islet Cell Tumour-Induced Hypoglycaemia (NICTH)

Non-islet cell tumour-induced hypoglycaemia (NICTH)

This is a rare para-neoplastic condition that occurs in cancer patients. It was first described in a patient with a hepatocellular carcinoma in 1929 by Nadler & Wolfer. The identification of ‘big IGF-II’ as the cause of NICTH was discovered in 1988 by Daughaday. In the current literature, most studies were case reports that describe the association of NICTH with different types of primary tumours. The exact incidence and prevalence of NICTH is unknown because this condition is usually unrecognized in cancer patients with hypoglycaemia.

The most common types of primary tumours associated with NICTH are those solid tumours of mesenchymal origin (e.g. mesothelioma, solitary fibrous tumours and haemangio-pericytoma) or epithelial origin (e.g. hepatocellular, gastric, lung, colon and non-islet cell pancreatic tumours). It can be rarely associated with tumours of haematopoietic and neuroendocrine origin. It is more prone to develop in patients with larger tumour burden

Pathophysiology

Insulin acts primarily on the liver, muscle, and adipose tissue; whereas the IGFs are important in the function of almost every organ in the body. IGF-I appears to have the predominant role in regulating growth, but the physiologic role of IGF-II is unknown. Insulin, IGF-I and IGF-II bind specifically to two high-affinity membrane-associated receptors that are tyrosine kinases. Insulin activates the insulin receptor while both IGFs activate the IGF-1 receptor. A third receptor, the IGF-II-mannose-6-phosphate receptor, binds IGF-II but has no known intracellular signaling actions. There are 70-80% of the IGFs form complexes with either IGF-binding protein-3 or IGF-binding protein-5 and an acid-labile subunit in normal human serum.

In NICTH, tumours produce and release an excessive amount of a prohormone form of IGF-II (often termed "big IGF-II"). Big IGF-II directly enhances insulin-like activity which leads to hypoglycaemia. It diminishes hepatic glucose production due to inhibition of glycogenolysis and gluconeogenesis, diminishes lipolysis in adipose tissue resulting in low serum free fatty acids levels and increases peripheral glucose consumption. In addition, increased big IGF-II concentration inhibits the secretion of insulin and growth hormone, and the reduction in serum growth hormone decreases the circulating levels of the ternary complex of IGF-I, IGF-binding protein-3, and the acid-labile subunit. Decreased concentrations of IGF-binding protein-3 further enhances the effects of circulating IGF-II

Clinical symptoms

Presentations of NICTH in cancer patients vary from loss of consciousness to subtle symptoms of hypoglycaemia, such as lethargy, sweating, and diminished motor activity with somnolence. The hypoglycaemic attack usually occurs between meals or in the morning with fasting hypoglycaemia. Furthermore, acromegaloid skin changes,
Hypoglycaemia in advanced cancer patients

Glucagon, growth hormone and glucocorticosteroids are recommended for the treatment of NICTH. Glucagon injection can correct hypoglycaemia by increasing hepatic glucose output. Hoff et al. found that glycaemic response to a glucagon stimulation test predicted good response to long-term treatment with glucagon (0.06–0.3mg/h), via continuous intravenous infusion\textsuperscript{10}. Growth hormone can increase glucose level and has been shown to be beneficial in the treatment of NICTH\textsuperscript{21}. The most effective long-term treatment is glucocorticosteroids. Its action is through stimulating glycogenogenesis and suppressing the production of big IGF-II and correcting the attendant biochemical abnormalities involving the growth hormone–Insulin-like growth factor axis. Moderate to high doses of glucocorticosteroids may cause shrinkage of the responsive tumour. The beneficial effects of glucocorticosteroids are variables, dose dependent and reversible. It is recommended that the dosage for treatment was prednisolone 30-60mg/day or dexamethasone 4mg/day\textsuperscript{22}.

Conclusion

Recurrent hypoglycaemia in advanced cancer patients is a common condition. NICTH should be considered with a high index of suspicion in case of refractory hypoglycaemia. There is more understanding about the pathophysiology of NICTH with the over-expression of big IGF-II and its action on the pathway of inducing hypoglycaemia. Prompt management with glucocorticosteroids is important as it is effective to correct hypoglycaemia and to relieve symptoms in palliative care patients.

References

Animal-assisted activity and animal-assisted therapy in palliative care

Dr Raymond WOO Kam Wing
Palliative Care Unit, Caritas Medical Centre
Correspondence: wookw@ha.org.hk

Abstract
There is growing evidence to support the role of animal-assisted activity and animal-assisted therapy in promoting patient’s health status. This article provides a brief introduction on the topic, as well as reviews the scientific evidence in both palliative and non-palliative setting.

HKSPM Newsletter 2013 Oct Issue 2 P29-31

Background

There is a special bonding between human and animals. According to the American Veterinary Medical Association, the human-animal bond is a mutually beneficial and dynamic relationship between people and animals that is influenced by behaviours that are essential to the health and well-being of both. The York Retreat founded by Quaker in 1790 revolutionized the concept of asylum for mentally ill patients by allowing patients to walk around in the garden to interact with those domestic animals. Nightingale also appreciated the role of small pet in accompanying the sick and the chronically ill. It was reported that the American Red Cross involved animals in the veteran’s rehabilitation.

Growing evidence and reports support the role of animals in facilitating health status of patients. Different organizations around the world have provided training to pets as well as the pet’s handlers to be the volunteers for patients. Doctor Pet (www.doctorpet.org.hk) is a Hong Kong-based non-profit organization pioneering Animal-assisted activity (AAA) and Animal-assisted therapy (AAT) promotion. In order to become a “Doctor Pet”, the pet would be assessed by the veterinary for their physical and psychological health, personality as well as coordination assessment. After passing the initial assessment, the pet and the owner need to attend 6 visits within 1 year before qualified to be “Doctor Pet”.

While there are so many terminology in the scientific literature describing the role of animals in helping patient’s health status, the Pet Partners (www.petpartners.org), or the formerly called the Delta Society, advised the avoidance of the term “pet therapy” which is misleading and inaccurate. They advocate using the term “AAA – animal-assisted activity” and “AAT –animal-assisted therapy”. According to Pet Partners, AAA was the causal “meet and greet” activities that involve pets visiting people, while AAT is a “goal-directed intervention and / or delivered by a health / human service professional with specialized expertise”.

What are the potential risks of AAA/AAT?

First of all, some patients, caregivers or staff may have allergies towards animal. Fear and even clinical phobia towards certain animals are not uncommon. In fact, the prevalence of cynophobia and other specific phobia are not known at that time. Moreover, there are concerns towards pet-associated zoonosis. Animal can be the carrier of pathogens like multi-resistant Staphylococcus aureus as well as Clostridium difficile. Liability remains an important and unsettled issue – despite intensive selection and training, any animals can bite unexpectedly. Besides the acute wound care, who is going to take up the legal responsibility if such extreme case happens?

AAA/AAT in rehabilitation, geriatric and psychiatric setting

There are already numerous randomized controlled trials on AAA/AAT conducted in different clinical settings. Cole et al. conducted a randomized control trial involving 76 advanced heart failure patients admitted to either cardiac care unit or cardiac observation unit. Patients were randomized into either a 12-minute visit from a volunteer with a therapy dog, a 12-minute visit from a volunteer, or the control group. It was found that the volunteer-dog group had significantly decrease in systolic pulmonary artery pressure and pulmonary capillary wedge pressure during and after the intervention. The presence of dogs was associated with greater decrease in levels of epinephrine and norepinephrine during and after the intervention when compared with volunteer only group. The authors noticed that volunteer-dog group had the greatest decrease from baseline in anxiety level as measured by State Anxiety Inventory when compared with other two groups.
Several randomized controlled trials provided evidence of AAA/AAT in patients with psychiatric disorders. Contact with dolphins for 2 weeks was shown to reduce depressive symptoms in patients with mild to moderate depression. Berget et al. from Norway had demonstrated the efficacy of AAT on top of standard therapies in patients with psychiatric disorder using farm animals. Ninety patients were randomized to either a 12-week intervention with farm animals or control group in 2:1 ratio. In the intervention group, patients visited the farm for three hours twice a week during which patients were required to work with the farm animals. It was found that the intervention group had significant increase in self-efficacy, coping ability but not quality of life. The 6 months follow-up assessment found that anxiety was significantly decreased when compared with baseline and the end of intervention. Such effect was not demonstrated during the intervention period.

Perkins et al. conducted a systemic review summarizing the evidence of dog therapy for elderly with dementia. There were 9 studies identified, however they were too heterogeneous to draw any conclusion. Increase in social behavior regardless the dementia severity, as well as decrease in agitated behaviour were the most reported benefits in the included research.

AAA/AAT in oncological setting

Can the benefit of AAA/AAT described above be extrapolated to the oncological setting? In a study performed in radiation oncology units, Johnson et al. randomly assigned 30 patients receiving non-palliative radiotherapy into dog visits, human visits and quiet reading session over a four-week period. Although there was statistically significant difference for mood and fatigue, participants receiving dog visits reported better self-perceived health.

Engelman also reported her results of 19 patients under palliative care who required intervention for pain management. The therapy dog used in her study was an 8-year-old, 13 pounds Bichon Frise certified by the Delta Society. According to the narrative report, all patients felt pleased with the therapy dog, with no patient reported negative feelings or increase in pain. A “hypnoanalgesia” phenomenon was observed in some of the patients – the somatic pain reduced when the dog was close to the pain location. The author also observed a decrease of staff stress levels. Another Italian study conducted among patients receiving chemotherapy showed that AAA could improve depression and increase their arterial oxygen saturation.

Recently Marcus et al. reported their findings on patient’s response towards therapy dog visits in a tertiary teaching hospital. Among 56 respondents, 33 encountered the therapy dog in the cancer infusion center. Symptom improvement was reported by the respondents, including stress reduction, improvement in mood and relaxation. Interestingly, about one fourth of the patients reported improved appetite and one third reported improved sleep. Unfortunately, only very limited information regarding patient’s cancer status and concurrent symptoms was provided in this study. For those who had negative or neutral experience, they probably would not bother to respond to the questionnaire, which contribute to the sampling bias.

Reflection on Hong Kong’s situation

According to bylaw 7.1.a, Chapter 113A of the Hospital Authority by-laws, no person shall have in his possession or under his custody or control any animal, bird or fish in a hospital. It simply means that pet cannot be bought to visit a terminally ill patient even he is taking the last breath. Can the policy of pet visits be reviewed?

Loneliness is the greatest existential challenge for patients facing end-of-life. Animals can be the good companion when we are facing suffering. Preliminary study suggests the role of AAA/AAT in palliative care setting. More studies in local situation, including patients, caregivers and staff’s perception, are urgently called for.
HKSPM Newsletter 2013 Oct Issue 2 P31

Editor’s Column

Dear members,

Greetings from the Editorial Board!

We would like to update on the changes in our Editorial Board. One of our editors, Dr. Mansha Khemlani has left Hong Kong to pursue her career in Singapore. We thank Mansha for her unfailing support to our Newsletter, and we wish her a brilliant future. A warm welcome to Dr. Steven Siu from Department of Clinical Oncology, Queen Mary Hospital, who joins us as one of the editors!

Last but not least, please mark your diary and join us in the coming Annual Scientific Meeting. You shall meet Dr. Sarah Booth from England and don’t miss the chance!

Dr. Doris Tse Man Wah

References:
7. Berget B, Ekeberg Ø, Braastad BO. Animal-assisted therapy with farm animals for persons with psychiatric disorders: effects on self-efficacy, coping ability and quality of life, a randomized controlled trial. Clinical Practice and Epidemiology in Mental Health 2008;4:29
9. Berget B, Ekeberg Ø, Pedersen I, Braastad BO. Animal-assisted therapy with farm animals for persons with psychiatric disorders: effects on anxiety and depression, a randomized controlled trial. Occupational Therapy in Mental Health 2011;27(1):50-64
“Doctor, I don’t want to live” – suicide in cancer patients

Dr. YP Tai, Dr TW Chan, Dr HL Leung, Dr KH Wong
Department of Clinical Oncology, Queen Elizabeth Hospital, Hong Kong
Correspondence: taiannahk@gmail.com (Dr. YP Tai), timctw@hotmail.com (Dr. TW Chan)

Abstract
Suicide in cancer patients is an uncommon but serious problem. In this article we will review some facts, risk factors and assessment tools for suicide in cancer patients in general. We will also share our experience in using the suicide screening tool and suicide precaution measures in Department of Clinical Oncology, Queen Elizabeth Hospital.

HKSPM Newsletter 2013 Oct Issue 2 P32-35

Case studies

Patient 1 – Mr. A

Mr. A, a 48-year-old man who enjoyed good past health, was diagnosed to have carcinoma of pancreas with multiple liver metastases. He received one cycle of palliative chemotherapy using Gemcitabine and Capecitabine in February 2013. He was married and had three children. He used to live in Shenzhen, but recently moved to live with his mother in Hong Kong for treatment of his cancer. He was unemployed, and financially dependent on his mother and three siblings. He was a chronic smoker and non-drinker with no substance abuse.

Mr. A was admitted to the Oncology ward in March 2013 for obstructive jaundice. Percutaneous transhepatic biliary drainage (PTBD) was then performed. It was a smooth procedure but he suffered from wound pain and insomnia afterwards. He developed low mood and attempted suicide on the same night by cutting his left wrist with a razor blade. His act was halted by a nurse who happened to pass by. Suicidal precaution was commenced at once. He was assessed by the on-call doctor and orthopaedic surgeon. As the wounds were superficial with no neurovascular injury or active bleeding, he was managed with daily dressing and sterile strips alone. In the next morning, his mood was stable and he denied any active suicidal ideation. Both clinical psychologist and psychiatrist suggested his attempt was a result of situational reaction to recent deterioration of physical condition. It was due to a restless impulse, which was not planned and not meant to end his life. The physical condition of Mr. A deteriorated gradually. He finally succumbed 1 week later.

Patient 2 – Mr. B

Mr. B, a 51-year-old man with history of osteogenic sarcoma of right scapula in 2001, was diagnosed to have carcinoma of buccal mucosa in October 2010. There was local recurrence of the buccal tumour in March 2011 and development of lung metastases in November 2011. He was referred to the palliative care clinic in June 2012. He was unemployed and married with no children. No history of substance abuse was noted.

Mr. B was admitted to the Oncology ward in February 2013 for progressive dyspnoea and suboptimal pain control. Chest X-ray revealed progression of lung secondaries. Symptoms improved with oxygen, morphine and oral antibiotics. On the day after admission, he attempted wrist cutting using a call bell, which was witnessed by his wife whom stopped his act. Suicidal precaution was commenced. The wounds were superficial with no active bleeding. Both clinical psychologist and psychiatrist suggested the attempt was a result of situation reaction to recent deterioration of physical condition and staying in a restricted ward environment.

Introduction
Suicide is the act of deliberately killing oneself. It is an important issue because it causes significant loss of potential life years to the society and also causes significant distress to the family members and friends of the deceased. In addition, suicide in the hospital setting can cause staff distress and potential medico-legal consequences. Nowadays, advances in cancer detection and treatment could improve cancer treatment outcomes and prognosis. It is therefore of great importance that we can prevent loss of oncological patients due to suicide.

Research has shown that people diagnosed with cancer are at an elevated risk of suicide and suicidal attempts compared to age- and gender-matched cohorts. It is due to the fact that the diagnosis of cancer and its subsequent treatment can be both physically and psychologically traumatic to the patient, thus causing a high level of distress.

Suicide occurs in persons of all ages and backgrounds. However, certain groups of people are at an increased risk for suicide attempts, including people with psychiatric illness and past history of attempted suicide. Studies have also found that males are more likely than females to commit suicide, although suicidal attempts are more common among females.
Prevalence of suicidal ideation and suicidal acts in cancer patients in literatures

Anna Robson et al looked into 11 studies investigating the prevalence of suicidal ideation. However, due to different populations and different methods of measurements used in the respective studies, there is great variation in the prevalence reported, ranging from 0.8-71%\(^3\). In the same review, 17 studies reporting the incidence of suicide in cancer patients were also analysed. The reported incidence of completed suicide in cancer patients ranged from standardised mortality ratio of 1 to 11. The wide range of results again may be attributable to variations in methodology, cultural differences, sampling frames, populations or sample size.

Statistics in Hong Kong

In Hong Kong, suicide causes more deaths than road traffic accidents and homicide\(^4\). In 2000, the death rate due to suicide was 13.4 per 100,000 population. According to figures from Hong Kong Cancer Registry, the age-standardized mortality rate for all cancer types in 2000 was 136.5 per 100,000\(^5\). The death rate due to suicide increases significantly after 60 years of age. This trend has been comparable to those of other industrialized countries.

Only a few studies looked at suicide in hospital setting in Hong Kong. Ho and Tay have described the characteristics of suicidal patients and their suicidal acts in general wards in Hong Kong between 2000 and 2002\(^6\). The suicidal acts mostly occurred in medical ward. Most of the patients who committed suicide were older than 50 years old and were mostly male. Nearly half of the patients committing suicide were admitted due to physical reasons. Only <10% were admitted due to abnormal mental state. Fewer than 20% were admitted because of attempted suicide. The largest proportion of patients had underlying neoplasm (26%), followed by cardiovascular or respiratory diseases. They tended to use lethal methods in wards including hanging or strangulation, jumping from height and poisoning. The incidents usually occurred after mid-night and in ward toilet.

Risk factors for suicide

The risk factors for suicide are multifaceted and complex, involving psychological, social, biological, cultural and environmental factors. Risk factors for completed suicide and suicidal ideation that apply to the general population can be extended to cancer population. In addition, there are a number of risk factors specific to cancer patients. Many studies have identified risk factors for completed suicide and suicidal ideation in cancer patients including mental health, socio-demographic, illness and general physical health characteristics\(^7,9\). These are listed in Table 1.

While suicide is not universally preventable, it is possible to recognize some warning signs and symptoms. It has been estimated that up to 75% of suicide victims display some warning signs or symptoms to their family members or friends. These include: making a will, getting one’s own affairs in order, suddenly visiting friends or family members for one last time, buying instruments for suicide like a gun, hose, rope, pills or other forms of medications, a sudden and significant decline or improvement in mood and writing a suicide note. However, these hints can be too subtle to be picked up. As a result, the importance of a sensitive and specific screening tool cannot be over-emphasized.

Assessment tools

Many measurement tools are available for the assessment of depression (e.g. Beck Depression Inventory\(^10\),

<table>
<thead>
<tr>
<th>Table 1. Risk factors for suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal / Social Background</strong></td>
</tr>
<tr>
<td>1. Access to lethal means (e.g., guns, drugs)</td>
</tr>
<tr>
<td>2. Family history of suicide</td>
</tr>
<tr>
<td>3. Past suicide attempts</td>
</tr>
<tr>
<td>4. Suicidal thoughts</td>
</tr>
<tr>
<td>5. Feelings of being a burden</td>
</tr>
<tr>
<td>6. Few or poor social support systems</td>
</tr>
<tr>
<td>7. Recent death of a friend or spouse</td>
</tr>
<tr>
<td>8. Use of opioids, sedatives or hypnotics and benzodiazepine</td>
</tr>
<tr>
<td><strong>Psychiatric/ Psychological Factors</strong></td>
</tr>
<tr>
<td>1. Psychiatric illness: anxiety disorders, depression</td>
</tr>
<tr>
<td>2. Impulsive behaviour (e.g. borderline personality disorder)</td>
</tr>
<tr>
<td>3. Hopelessness/ despair/ distress</td>
</tr>
<tr>
<td>4. Diminished mood</td>
</tr>
<tr>
<td>5. Post traumatic stress disorder</td>
</tr>
<tr>
<td>6. Poor coping</td>
</tr>
<tr>
<td>7. Substance abuse</td>
</tr>
<tr>
<td><strong>Physical Factors</strong></td>
</tr>
<tr>
<td>1. Poor physical functioning</td>
</tr>
<tr>
<td>2. Poor sleep quality or insomnia</td>
</tr>
<tr>
<td>3. Unrelieved pain</td>
</tr>
<tr>
<td>4. Delirium</td>
</tr>
<tr>
<td>5. Other significant symptoms, e.g. mucositis, dyspnoea, vomiting, diarrhoea, skin rash, etc.</td>
</tr>
<tr>
<td><strong>Cancer Factors</strong></td>
</tr>
<tr>
<td>1. Advanced age</td>
</tr>
<tr>
<td>2. Advanced stage of disease</td>
</tr>
<tr>
<td>3. Poor prognosis</td>
</tr>
<tr>
<td>4. Physical impairments (e.g., loss of mobility, vision, or hearing; incontinence; amputation; paralysis; inability to eat or swallow; exhaustion; fatigue)</td>
</tr>
<tr>
<td>5. Confusion or delirium</td>
</tr>
<tr>
<td>6. Loss of control or helplessness</td>
</tr>
<tr>
<td>7. Uncontrolled pain</td>
</tr>
</tbody>
</table>

“Doctor, I don’t want to live” – suicide in cancer patients
The Queen Elizabeth Hospital experience

In Department of Clinical Oncology, Queen Elizabeth Hospital, there were 8 recorded cases of suicidal attempts or completed suicide from 2003 to March 2013. Among these 8 patients, 6 successfully completed suicide while 2 were rescued. Six occurred after discharge while 2 occurred during their in-patient stay. Nearly all of them were admitted due to physical symptoms such as poor pain control, but none of them were noted to have history of psychiatric illness. In order to prevent suicidal attempts or acts in our patients, we looked up the literature for some common risk factors and devised a screening tool which aimed at identifying patients at risk upon admission while maintaining a reasonable workload for the staff (Figure 1). Twelve risk factors including physical symptoms, demographic and psychiatric factors were included and given a weighting. Patients were screened by the nurses on admission. If they were noticed to have a significant risk of suicide, clinical psychologist will be consulted for assessment. If patients were noticed to have suicidal attempt or ideation upon admission, measures for suicidal precaution will be carried out immediately and clinical psychologist and/or psychiatrist will also be consulted.

Three important principles to prevent in-patient suicidal attempts are awareness, safe environment and constant observation.

1. Awareness

Cancer patients are considered at high risk for depression. As medical professionals in oncology, we need to be alert and observant. Special attention to patients with low mood and disturbing symptoms, including those who verbalized any idea or plan of self harm is of great importance. For patients who are put on suicidal precaution, we need to notify all the staff concerned and the case should be handed over in every shift, upon transferal or discharge. A ‘Suicidal Precaution’ alert should be placed on top of the patient’s medical record, as well as on top of the patient’s bed to arouse the staff’s awareness. Patient’s relatives should also be informed of the risk so that we can achieve a good liaison with them.

2. Safe environment

We should ensure a safe environment both physically and psychologically for the patients who are at high risk of suicide attempt or under suicidal precaution. Physically, these patients should be placed in a safe location in ward, e.g., away from windows. Dangerous items, such as sharp objects, glass, strings and ropes should be put away from the patient’s reach. Prescribed drugs should also be taken in the presence of nursing staff to prevent stocking and overdose later. Physical restraint should be applied as a last resort if it is unavoidable. Psychologically, our medical staff should try our best to be friendly, helpful and supportive to the patients.

3. Constant observation

Patient’s condition including pain and mood could change from time to time. Therefore, we need to observe the patient in every shift for any abnormal behaviour, and to manage physical symptoms (especially pain and insomnia), psychological elements (e.g. negative feeling) and any psychiatric symptoms (e.g. hallucination) with the help of clinical psychologist and psychiatrist when necessary.

Conclusion

To reduce the suicidal risk in cancer patients, adequate training should be provided to oncology staff. A high index of suspicion about suicide, sensitive screening tools for risk factors and practical suicidal precaution protocols are all essential to the success of suicide prevention. Besides, adequate symptom relief, identification and referral for treatment of underlying psychiatric problems such as depression, alcohol and substance abuse, and detection of significant psychosocial problems are keys to reduce suicidal risks. Therefore, a multidisciplinary input including oncologists, nurses, social workers, clinical psychologists, psychiatrists, physiotherapists and occupational therapists is very important.

Apart from focusing on the patient, we should also pay attention to their family members or carers who can be in significant stress. According to a Korean study, 17.7% of caregivers reported suicidal ideation and 2.8% had attempted suicide. The risk factors included female, single, unemployment and financial difficulty. Lastly, good documentation and incidence reporting are crucial, not only for medico-legal purpose but also for the subsequent analysis for improvement.

References

3. Robson A, Scrutton F, Wilkinson L, MacLeod F. The risk of

Figure 1. Suicidal Risk Assessment Form in Queen Elizabeth Hospital

<table>
<thead>
<tr>
<th>Apparent Suicidal Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Patient expressed suicidal / self-harm behaviour</td>
</tr>
<tr>
<td>● Disclosure by relatives/ friends that patient has suicidal idea</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Risk Factors:</th>
<th>Y</th>
<th>N</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Significant Physical Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Poorly-controlled pain</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ Sleep disturbance/ Insomnia</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ Other significant symptoms e.g. diarrhoea/ skin rash</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>B. Demographics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Recent newly diagnosed cancer / progression of disease</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ Lives alone/ lack social support</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ Recently separated/ divorced/ widowed</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ Recent major life/ social events/ loss/ bereavement</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ History of suicidal attempt</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>C. Psychiatric Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ History of psychiatric illness e.g. schizophrenia, depression, personality disorders, etc</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ History of substance abuse, e.g. alcohol, drugs</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>□ Depressive mood and hopelessness</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>□ Evidence of withdrawal</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total Score:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If >= 6, Refer Clinical Psychologist for Assessment

“Doctor, I don’t want to live” – suicide in cancer patients
Want to join us?

Hong Kong Society of Palliative Medicine
Membership Application/Renewal Form

1. PERSONAL PARTICULARS
Surname ________________________ First name ________________________ (BLOCK LETTER)
Contact tel number ________________________ (Office) ________________________ (Mobile)

2. OTHER INFORMATION (Renewal members do not need to fill unless information has changed)
Corresponding Address (BLOCK LETTER)__________________________________________
__________________________________________ E mail _______________________________
Current Practice □ HA □ DH □ Private □ HKU □ CUHK □ Others
Name of institution______________________________________________________________
Title (Dr. Mr. Ms. Mrs. etc) __________ Profession ________________________________

Membership Applied for / Renewed: □ Full Membership □ Associate Membership
I, the undersigned, is hereby applying for / renewing full membership / associate membership (delete if inappropriate) of Hong Kong Society of Palliative Medicine.
Applicant Signature:________________________ Date:________________________
Proposer:________________________ (BLOCK LETTER) Signature____________________
(for new application)

FOR OFFICIAL USE ONLY
Approved on___________(date) for □ Full Membership □ Associate Membership
Membership fee paid for yr __________ Cheque No __________ Amount __________

Membership Information
Full Member – Any local registered doctors interested in the field; annual fee HK$150
Member – Other professional workers interested in the field; annual fee HK$50
Please send by mail the completed application form, together with a crossed cheque (payable to “Hong Kong Society of Palliative Medicine Limited”) to:

Hong Kong Society of Palliative Medicine Ltd,
c/o Dr. Inda SOONG
Dept of Clinical Oncology, Pamela Youde Nethersole Eastern Hospital
3 Lok Man Road, Chai Wan, Hong Kong.

Chairman
Dr. LIU King Yin, Rico
Vice-Chairmen
Dr. LO See Kit, Raymond
Dr. LAM Po-tin
Honorary Secretary
Dr. LAM Wai-man
Honorary Treasurer
Dr. SOONG Inda
Council Members
Dr. CHAN Kin-sang
Dr. SHAM Mau-kwong, Michael
Dr. TSE Man-wah, Doris
Dr. YAU Sau-han, Yvonne
Dr. YUEN Kwok Keung
Dr. LAU Kam-shing
Dr. MAK Yi-wood, Yvonne
Dr. WONG Kam-hung
Dr. KWOK Qi-ling, Annie
(ex-officio)
Editorial Board
Dr. TSE Man Wah, Doris
(Editor-in-Chief)
Dr. Dr. LAU Kam Shing
Dr. CHEN Wai Tsan, Tracy
Dr. Mansha Hari KHEMLANI
Dr. CHAN Tze Mim, Jasmine
Dr. NG Sheung Ching, Jeff
(ex-officio)
Honorary Advisors
Dr. Derek DOYLE
Prof. Ilora FINLAY
Prof. Sir David TODD
Prof. Rosie YOUNG
Dr. POON Yuet Foo
Dr. TSE Kin Chuen, Vincent
Dr. TSE Chun Yan
Honorary Legal Advisor
Gallant Y.T. Ho & Co. Solicitors & Notaries
Honorary Accountant
Yong Zheng CPA Ltd
Palliative Medicine Doctors’ Meeting (PMDM)  
Every 2 months, Tuesday

Multidisciplinary Meeting (MDM)  
Every 4 months, Tuesday

Organisers: Hong Kong Society of Palliative Medicine, Training Subcommittee CC on Palliative Care, HA; Hong Kong Palliative Nursing Association

Time: 5:30 PM Refreshment, 6:00 to 7:30 PM Lecture

Venue: Lecture Theatre, G/F, M Block, Queen Elizabeth Hospital

Enquiry: Dr. Raymond Lo, Chairman, Scientific Subcommittee, HKSPM, c/o Dept of Medicine & Geriatrics, Shatin Hospital,
Tel 2363 7500 Fax: 2647 7850

Date & Presenting Units

Nov 2013
ANNUAL SCIENTIFIC MEETING

28/1/2014
Prince of Wales Hospital
Ruttonjee and Tang Shiu Kin Hospitals

25/3/2014
Grantham Hospital
Shatin Hospital

29/4/2014
Tuen Mun Hospital
Caritas Medical Centre

29/10/2013
Queen Elizabeth Hospital
Our Lady of Maryknoll Hospital

25/2/2014
Queen Mary Hospital
Ruttonjee and Tang Shiu Kin Hospitals

Note:
The meeting schedule is based on the information at time of printing.
Please refer to the latest announcement for confirmation.

Palliative Medicine Grand Round
Monthly Tuesday 6:00 - 8:00 PM

<table>
<thead>
<tr>
<th>Date</th>
<th>Case Presentation</th>
<th>Journal Review</th>
<th>Chairman</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Oct 2013</td>
<td>Dr Jerry HO</td>
<td>Dr MA Chi-ming</td>
<td>Dr LAM Wai-man</td>
<td>Conference Room, G/F, Annex Building, HHH Rm 2, LG1, RH</td>
</tr>
<tr>
<td>5 Nov 2013</td>
<td>Dr POON Yin</td>
<td>Dr Eric LAM</td>
<td>Dr FAN Hon-cheung</td>
<td>Conference Room, G/F, Annex Building, HHH</td>
</tr>
<tr>
<td>3 Dec 2013</td>
<td>Dr CHEN Tracy</td>
<td>Dr Alice MOK</td>
<td>Dr Doris TSE</td>
<td>Conference Room 1/F, SH</td>
</tr>
<tr>
<td>7 Jan 2014</td>
<td>Dr Benjamin CHENG</td>
<td>Dr CHEUNG Wai-yin</td>
<td>Dr Raymond LO</td>
<td>Conference Room D, 1/F, OPD Block, OLMH</td>
</tr>
<tr>
<td>11 Feb 2014</td>
<td>Dr Toni AU</td>
<td>Dr Jeff NG</td>
<td>Dr Jasmine CHAN</td>
<td>6/F Conference Room KTSHC, GH</td>
</tr>
<tr>
<td>4 Mar 2014</td>
<td>Dr Deepa NATARAJAN</td>
<td>Dr Cora YAU</td>
<td>Dr CHAN Kwok-ying</td>
<td>Conference Room, G/F, Annex Building, HHH Rm 2, LG1, RH</td>
</tr>
<tr>
<td>1 Apr 2014</td>
<td>Dr POON Yin</td>
<td>Dr MA Chi-ming</td>
<td>Dr CHAN Kin-sang</td>
<td>Conference Room, G/F, Annex Building, HHH Rm 2, LG1, RH</td>
</tr>
<tr>
<td>13 May 2014</td>
<td>Dr CHAN Chung-on</td>
<td>Dr WOO Kam-wing</td>
<td>Dr LAU Kam-shing</td>
<td>CMC (venue to be confirmed)</td>
</tr>
<tr>
<td>3 June 2014</td>
<td>Dr Jerry HO</td>
<td>Dr. Alice MOK</td>
<td>Dr. Annie Kwok</td>
<td></td>
</tr>
</tbody>
</table>
Dear golfers and friends,

The Inauguration of our "Home for Hospice" will be in 2015!

Our mission to create this first-of-its-kind homelike hospice centre in Hong Kong in providing professional spiritual, psychological as well as medical support for the terminally ill patients yet to be completed soon!

In supporting this meaningful task, the Society for the Promotion of Hospice Care (SPHC) will hold its first Charity Golf event for fundraising in supporting the new project, "Home for Hospice". In 2012, Hong Kong Jockey Club Charities Trust Fund generously granted us the fund for construction of the building. However, apart from the construction cost, funding to cover furniture and equipment still needs to be raised. Well, good news to be shared here that the building will have its Ground Breaking Ceremony taken on 24 October 2013.

SPHC, with deep appreciation, would like to express our thanks to many athletes and donors in supporting the promotion of hospice services over twenty years through different activities like Hiking, Charity Film Gala etc.

CHARITY HOLE IN ONE

On 28 November 2013, we will get involved the passionate golfers to join our first Charity Golf event, the Charity Hole in One, which is not only a charity activity, but also a golf tournament to share your golf skills.

Date: November 28, 2013 (Thursday)
Venue: Discovery Bay Golf Club, Lantau Island, Hong Kong.

Visit our website at: http://www2.hospicecare.org.hk/who-we-are/news-media/upcoming-events/ents/
Simply form your team, fill in the form at website or contact us for the enrolment forms at 2868 1211. Kindly RSVP before October 25, 2013.

We are glad to be supported by The Artiste Golf Association of Hong Kong for this golf event and we look forward to your participation too!

For more information of the Charity Hole in One, please feel free to call Ms. Janet Lau at 2868 1211.

SPHC has organised the Hike for Hospice, our signature annual fundraising event every year since 1992. Our Hike for Hospice 2014 is in full swing! Please join us once again to both participate in and back this wonderful Hike that gives us the means to continue our important work of adding life to the days of those who are in need of our support.

Can we count on your continued help?
Date: 9 March 2014 (Sunday)
Venue: Tai Lam Country Park
For more information: https://www.facebook.com/hikeforhospice
Enquiry: 2868 1211

Break out your walking shoes and hike with us in the beautiful outdoors!
At Christmas time, many of us rejoice together and enjoy Christmas Carols which are indispensable in spreading joy, hope and love. However, how many would prioritise to help those who are hindered by life-threatening illness from enjoying just a simple festival? Light Up A Life Christmas Concert is organised for extending care, love and benevolence to these families. This Christmas, the Chairlady of our Concert, Mrs. Sally Thompson, is leading another joyous, inspiring evening for us to raise funds to “light up” the life of these terminal patients and their family members while remembering our late friends and loved ones. Count yourself in for this important cause and have a memorable, wonderfully warm Christmas!

Date: 3 December 2013 (Tuesday)
Time: 7:30 pm – 9:30 pm
Venue: St John’s Cathedral, 4-8 Garden Road, Central
Tickets: HK$200 (Available in the Cathedral bookstore in November upon announcement.)
Enquiry: 2868 1211

SHPH is fortunate to gain supports from the Cantonese Opera group (藝群粵劇團). We are joining hands together to organise a charity concert to raise funds for our services while helping to promote our work. The music programmes for the night will include five popular Cantonese Opera excerpts (折子戲), to be performed by renowned Cantonese Opera artists Franco Yuen (阮兆輝), Lung Kwan Tin (龍貫天), Lee Chow Yuen (李秋元), Lau Wai Ming (劉惠鳴), Wan Yuk Yu (溫玉瑜), Hung Hoi (洪海), Chan Ka Ming (陳嘉鳴), and Wong Chiu Kwan (王超群). We are also fortunate to have invited Ms Poon Bing Sheung (潘冰嫦) as MC for the ceremony.

Date: 28 February 2014 (Friday)
Time: 7:30 pm – 10:30 pm
Venue: Sunbeam Theatre, North Point
Tickets: HK$1200, HK$500, HK$300, HK$100
(Available in the Sunbeam Theatre in January upon announcement.)
Enquiry: 2868 1211