Tan Tock Seng HOSPITAL

A PUBLICATION FOR PRIMARY CARE PHYSICIANS

GP BUZZ

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APRIL-JUNE 2016

SURGICAL TREATMENT OF LIVER METASTASES FROM GASTRIC CANCER

IT'S NOT THAT HARD TO STAY HARD

UPDATES ON COMMUNITY RIGHT SITING PROGRAMME

Scan the QR code using your iPhone or smart phone to view GP BUZZ on the TTSH website or visit **www.ttsh.com.sg/gp/**.

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APRIL - JUNE 2016

« Heavily-suited Hazardous Materials Decontamination Team drilling at the Emergency Department, April 2016

About the Cover Page: Tan Tock Seng Hospital Civil Emergency Preparedness

On a bright Saturday morning in November 2015, more than a 100 leaders from key clinical and operational departments in Tan Tock Seng Hospital (TTSH) gathered for a table-top exercise to rehearse and review response plans in the event of a civil emergency. Such scenario rehearsal exercises are held regularly throughout the year, alongside physical training and technical drills, as TTSH painstakingly readies itself for handling large scale public health and civil emergencies. This work continues on top of TTSH's 24-hour mission as the acute and tertiary care hospital for the residents of central Singapore. GPBUZZ

Zika – Getting the Facts Right

Adjunct Associate Professor Lim Poh Lian, Head of Travellers' Health & Vaccination Clinic and the Department of Infectious Diseases, addresses the concerns regarding the Zika virus outbreaks in the Caribbean and Latin American countries:

FACT: Zika is a viral infection transmitted by the bite of infected Aedes mosquitoes. The common symptoms are fever, body aches, headaches and rashes, and occasionally, conjunctivitis.

FACT: Pregnant women should be advised against non-essential travel to countries with Zika infections. If they need to travel there, they should take strict precautions against mosquito bites.

FACT: If your patient develops viral fever symptoms within 14 days of returning from countries with Zika infection, you should test for Zika using a serum PCR. The blood sample should be sent to the National Public Health Laboratory (NPHL). Information about how to send the test for Zika is included in the recent Ministry of Health (MOH) circular to all doctors. Suspected or confirmed Zika infection should be notified to MOH. If the patient has confirmed Zika infection, the patient will need to be admitted for the duration that he/she has Zika virus in the blood, to prevent Zika from spreading in Singapore. GPBUZZ

EMPOWERING THE COMMUNITY

Since 2010, Tan Tock Seng Hospital (TTSH) regularly conducts two community health engagement programmes, which focus on empowering individuals and their caregivers on better health management.

TAKE CHARGE! CHRONIC DISEASE SELF-MANAGEMENT PROGRAMME (CDSMP)

Developed by Stanford University and organised by the National Healthcare Group (NHG) and TTSH, CDSMP is a stepped programme that teaches active self-management to enhance the quality of life and self-efficacy.

CDSMP has been shown to improve symptom control, medication usage and utilisation of healthcare resources, and aims to benefit patients with chronic diseases, as well as their caregivers.

"As I continue with making action plans, my health behaviour, symptom management and communication with healthcare providers has significantly improved."

- Thomas Lam, CDSMP participant

ENGAGE IN LIFE (EIL)

"After each session, we were given homework. This was especially good so that we could recap what we have learnt in the classroom. Thereafter, we were able to plan out the programme which was suitable to our individual needs."

- Audrey Yip, EIL participant

Through a series of six workshop sessions, participants learn about areas of successful ageing from healthcare experts. Many participants also move on to form their own networks of friends, and continue engaging actively in life.

EIL is open to anyone above 40 years old and interested in making changes to their lives. It is conducted in both English and Mandarin.

Through CDSMP and EIL, TTSH hopes to share the necessary knowledge and skills to build a network of healthy agers within a healthier community.

GPBUZZ

For referrals to CDSMP and EIL or requests for brochures, please contact us at **chep@ttsh.com.sg** or **6359 6439/6419**. More information can also be found on our websites: **www.ttsh.com.sg/CDSMP and www.ttsh.com.sg/EIL.**

Scan this QR code to find out more on our Facebook page.

THE DANGER WITH DENGUE

By **Dr Barnaby Young**, Consultant, Department of Infectious Diseases, Institute of Infectious Diseases and Epidemiology (IIDE), Tan Tock Seng Hospital

The Adult Dengue Platelet Study randomised controlled trial (ADEPT-RCT) under the STOP Dengue Programme was recently concluded. The study randomised almost 400 individuals with dengue, a platelet count of <20 x 10^9/L, and no bleeding, to prophylactic platelet transfusion or supportive care.

Transfusion benefits on platelet counts were transient and disappeared by the third day. Transfusion was also complicated by more frequent adverse effects such as fever.

Severe dengue is usually the result of plasma leakage or organ impairment, rather than bleeding. Identifying who is at risk for severe dengue early in the course of the illness can be difficult. The platelet or white blood cell counts are not typically useful. Instead, the World Health Organisation recommends assessing patients daily for warning signs such as abdominal pain, persistent vomiting or clinical fluid accumulation. Those who develop these signs or who are at a higher risk for complications (e.g. the elderly, pregnant, or individuals with chronic kidney disease) should be referred to a hospital for further management. GPBUZZ

ERECTILE DYSFUNCTION AS NEW RIGHT-SITING TRACK FOR TAN TOCK SENG HOSPITAL COMMUNITY RIGHT SITING PROGRAMME (CRISP)

Dear Partners and Friends,

With effect from 1 February 2016, Tan Tock Seng Hospital (TTSH) will commence right-siting of patients with Erectile Dysfunction (ED), a non-CHAS condition, to our General Practitioners (GP) partners as part of the TTSH Community Right-Siting Programme (CRiSP).

Our pharmacy will continue to support GP partners in care management through the provision of any necessary ED drugs upon doctor's prescription.

We are also pleased to share that TTSH Department of Urology provides a suite of Andrology and Men's Health services for patients suffering from complex urological issues. Find out more about managing ED in Primary care as well as the range of second line treatment for ED in our feature article '*It's not that Hard to Stay Hard*' on page 4.

Thank you for your continuous support, and we look forward to working closely with you. GPBUZZ

Associate Professor John Abisheganaden
Clinical Programme Director - CRiSP
Head and Senior Consultant
Department of Respiratory and Critical Care Medicine
Tan Tock Seng Hospital

CRiSP is a partnership between TTSH and our GP partners where stable patients at Specialist Outpatient Clinics with selected chronic conditions are appropriately reviewed and managed at the GP setting.

Currently, CRiSP is implemented in the following regions:

1. **Ang Mo Kio**
2. **Bugis**
3. **Balestier**
4. **Boon Keng**
5. **Puggol**
6. **Seng Kang**
7. **Whampoa**
8. **Woodlands**
9. **Yishun**

If you would like to find out more about TTSH's Community Right-Siting Programme (CRiSP), please contact:

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IT'S NOT THAT HARD TO STAY HARD

By **Dr Ronny Tan**, Consultant, Department of Urology, Tan Tock Seng Hospital

Erectile Dysfunction (ED) is defined as the inability to achieve or maintain a sufficient erection for satisfactory sexual performance. It has been reported that ED affects men, regardless of age, at one point in their lives.

The first line of treatment for ED would be oral phosphodiesterase type 5 inhibitors (PDE5i). Locally available PDE5i include sildenafil, vardenafil and tadalafil. As PDE5i work only on the vasculature of the penis, they have no effect on libido, and should not be considered an aphrodisiac. PDE5i are safe and well-tolerated by men. However, men on nitrates are not suitable to use PDE5i.

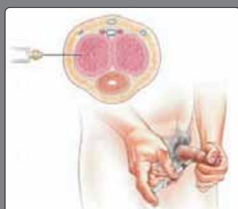
As such, we can consider second-line treatment or other adjunctive treatment modalities that can be discussed further in the andrology clinic.

One viable option would be self-administered intra-cavernosal injections (ICI). The commonly used local preparation is alprostadil 20mcg (a prostaglandin E1 analogue). Unlike PDE5i, after ICI, erections usually occur within minutes, independent of sexual stimulation. The main side effect of ICI would be priapism (persistent erections without sexual stimulation), and we would advise men on ICI to make a trip to the Emergency Room if the erections fail to wear off after 2 hours.

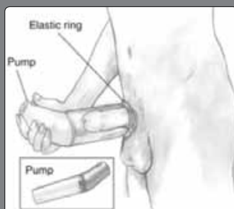
Vacuum Erection Devices (VED) work by drawing both venous and arterial blood into the penis, to cause engorgement of the erectile tissue. Venous return is subsequently obliterated with a constriction ring, placed at the base of the penis. VEDs can be used with PDE5i and ICI to improve the rigidity of the penis, to allow for satisfactory sex. The main drawback is the discomfort during ejaculation, due to the penile ring.

Low intensity extracorporeal shockwave treatment (LiESWT) for erectile dysfunction is a novel treatment for vasculogenic ED. Studies have shown that men who previously experienced poor efficacy with PDE5i became responsive to PDE5i after LiESWT, and men with sub-optimal results using PDE5i report improved erections after LiESWT. This is a non-invasive treatment where low intensity shockwaves are delivered to the penis, causing neovascularisation (growth of new blood vessels) to improve the blood flow to the penis, hence resulting in better erections. LiESWT is a potential cure for ED and is carried out in the office setting, without any need for anaesthesia or painkillers. Patients tolerate the procedure well and even patients who are on aspirin or other blood thinners are suitable for this modality of treatment.

The current cure for ED is the placement of a Penile Prosthesis, which is a day surgical procedure where a permanent implant is placed into the patient's body via a small peno-scrotal incision (where the base of the penis meets the scrotum), and the patient will be able to use the prosthesis 6 weeks later. Options include the inflatable penile prosthesis (with a physiological flaccid state on deflation) and the malleable semi-rigid penile prosthesis. GPBUZZ



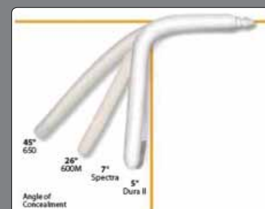
Intra-cavernosal injection (ICI) technique



Vacuum Erection Device (VED)

Low intensity extracorporeal shockwave treatment (LiESWT)

3-piece Inflatable Penile Prosthesis in situ



Malleable Semi-Rigid Penile Prosthesis

Images used with permission from Medispec Ltd and Boston Scientific AMS.

FEATURE

SURGICAL TREATMENT OF LIVER METASTASES FROM GASTRIC CANCER

Scan this QR code to read the article online.

By **Adjunct Assistant Professor Vishalkumar G Shelat**, Consultant, Hepato-Pancreato-Biliary Surgery Service, Department of General Surgery, Tan Tock Seng Hospital

Gastric cancer is the fourth most common type of tumour, and the second cause of cancer-related death worldwide. The incidence of gastric cancer liver metastases (GCLM) during the course of the disease varies between 30% and 50%. In particular, metachronous GCLM after curative gastrectomy are detected in up to 25% to 30% of patients, 80% of which appear within the first two post-operative years.

Surgical treatment of GCLM is currently reason of great debate. Hepatectomy is performed in only 0.4% to 1% of GCLM, because most GCLM are multiple, bilateral, and combined with peritoneal or lymph node metastases. Resection was initially indicated in patients with synchronous metastases who had no peritoneal dissemination or other distant metastases and in patients with metachronous metastases without any other detectable lesion, only if a complete resection of the metastases could be achieved without compromising liver function. Recent meta-analysis agrees that the best survival rates are associated with surgical treatment, which should be chosen whenever possible. In addition, the overall 5-year survival rate of metastatic gastric cancer ranges between 0% and 10%, whereas it rises up to 20% after hepatectomy. In Singapore, surgery for GCLM is not widely practiced – the following is an account of our first patient who underwent liver resection for GCLM.

Mr A is a 71-year-old gentleman with a history of hepatitis B infection and gastric cancer. He underwent total gastrectomy in July 2014 and is on regular follow-up since then. His scan in January 2016 showed a liver lesion and this was adjudged to be GCLM or a primary liver cancer (Image 1). Liver biopsy showed adenocarcinoma and was not able to differentiate between primary liver cancer versus GCLM. A PET scan was arranged and this showed a solitary lesion in the liver. A multidisciplinary tumour board meeting agreed that we could offer surgery for GCLM, if the patient is a fit candidate and if the surgeon deems that liver surgery would be a safe procedure. There was a possibility that this was a primary liver cancer and in such an instance, surgery was recommended. Patient was made aware of all this and he agreed to surgery. He underwent liver resection and his hospital stay was uncomplicated. He was discharged on the fifth post-operative day. His final histology report is similar to previous gastric cancer. His is a case of GCLM that underwent liver resection after being disease-free for 18 months. Mr A remains well after 4 months' follow-up.

A parallel can be drawn is that fit and young patients with a small number of GCLM, and without extra-hepatic disease could be offered liver surgery. The availability of metabolic imaging (e.g. FDG-PET) now permits for the selection of a more appropriate treatment modality, by detecting distant metastases. Mr A's PET scan was clean – except for the solitary liver lesion (Image 2). Taking into account local procedures for hepatic metastases, general consensus on management of GCLM includes adjuvant chemotherapy, molecular targeted therapy, or palliative supportive care. In metastatic disease, surgery offers an additional option of cure.

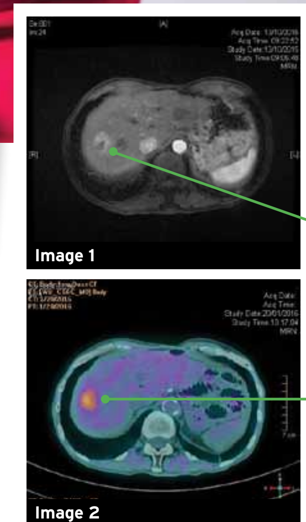


Image 1 — MRI scan showing liver metastases

Image 2 — PET scan showing liver metastases

In summary, despite the possible presence of a selection bias, recent studies still show improved survival for GCLM. Multidisciplinary discussion, patient selection, absence of additional secondary tumours or extra-hepatic metastases is essential components prior to offering surgery for GCLM. An individual clinician is obliged to remain open-minded about possible options in patients with GCLM, and each patient must be provided with information on advances in oncology to aid in making an informed decision, which is paramount to personalised cancer care. GPBUZZ

Scan this QR code to read the article online.

EYE DISCOVERIES: A BETTER UNDERSTANDING OF KERATOCONUS

By Clinical Associate Professor Heng Wee Jin, Senior Consultant, Head of Cornea & Refractive Surgery (LASIK), Department of Ophthalmology, Tan Tock Seng Hospital, National Healthcare Group Eye Institute

AN INTRODUCTION TO THE NATIONAL HEALTHCARE GROUP (NHG) EYE INSTITUTE, AND KERATOCONUS

Since its inception in 2001, the NHG Eye Institute has continued to address the increasing demand for eye care services, research and training. It incorporates Tan Tock Seng Hospital's (TTSH) Department of Ophthalmology as its flagship clinical unit, and delivers quality tertiary and primary eye care to patients in Singapore and the region. With more than 32 fellowship-trained consultants on-board, the Institute covers the entire spectrum of ophthalmic sub-specialties, providing comprehensive diagnosis and advanced treatment for both common and complex eye diseases.

In part one of 'Eye Discoveries' series by the NHG Eye Institute, we will be taking a look at Keratoconus – its cause, symptoms and treatment options.

What Is Keratoconus?

Keratoconus is an uncommon condition in which the cornea (the clear front window of the eye) becomes progressively thin and protrudes outward. Keratoconus literally means a conical-shaped cornea, which is an abnormal shape that can cause serious distortion and reduction of vision.

What Causes Keratoconus?

Despite ongoing research efforts, the cause of Keratoconus remains unknown. Although Keratoconus is not generally considered an inherited disorder, it still presents a high chance of one in ten individuals having a blood relative with the condition.

Eye irritation from vigorous rubbing, although not the cause of Keratoconus, can contribute to the disease's progression. Therefore, patients with Keratoconus are advised to avoid rubbing their eyes.

A patient with Keratoconus

Other risk factors include medical conditions such as Marfan's syndrome, Ehlers-Danlos syndrome, Down syndrome, hay fever, and vernal keratoconjunctivitis.

What Are The Symptoms Of Keratoconus?

At the onset of the disease, patients may be asymptomatic, with their vision only slightly affected. Symptoms usually appear during a patient's late teens or early twenties, in the form of increasingly blurred and distorted vision. In the early stages, there may be no obvious findings on slit-lamp examination of the cornea, and the diagnosis can only be made by computerised corneal topography.

As the disease progresses and the cornea steepens, significant astigmatism develops, and vision becomes noticeably distorted. Subsequently, increased myopia and astigmatism result in spectacle intolerance or irregular astigmatism, which cannot be optimally corrected by spectacles. This may necessitate the use of rigid contact lenses. Keratoconus usually affects both eyes, though each eye may be affected differently. The disease will often progress throughout a patient's mid-thirties, at which time progression slows and often stops.

During the course of the disease, the cornea can suddenly develop edema (acute hydrops) when a tiny dehiscence occurs in the internal layers of the cornea caused by the stretching of the cornea protrusion. This results in a sudden decrease in vision, irritation, glares and halos. The swelling may persist for weeks or months while the crack heals and is gradually replaced by scar tissue.

Diagnosing Keratoconus

Diagnosis is made by the eye specialist via slit-lamp examination, keratometry, retinoscopy and corneal topography, which can demonstrate evidence of corneal protrusion and irregularity.

How Is Keratoconus Treated?

Mild cases can be successfully treated with prescription spectacles or specially-fitted contact lenses. When vision is no longer satisfactory even with the use of glasses or contact lenses, surgery is often recommended.

When progression of the disease is found to be rapid, particularly among younger patients, Cornea Collagen Cross-linking may be performed to stiffen the patient's cornea, so as to arrest progression of the disease.

To treat a moderately-protruded cornea, intra-corneal ring segment implantation can be considered. The

ring segments mould the cornea into a rounder shape, with the main aim of allowing a better contact lens fitting. If hydrops occurs, eye drops may be prescribed to reduce corneal edema and prevent infection.

In severe cases of Keratoconus, or significant corneal scarring, corneal transplantation (keratoplasty) will be necessary. This can take the form of lamellar (partial-thickness) or penetrating (full-thickness) keratoplasty. A deep lamellar keratoplasty (DALK) preserves the inner-most layer of the patient's cornea (endothelium), and helps avoid rejection of this critical lining that preserves the optical clarity of the cornea.

Keratoconus enjoys one of the highest success rates among all types of corneal transplantation, but possible complications which include graft rejection, astigmatism, intolerance to contact lens wear and infection can still occur and patients may require long-term follow-up after surgery.
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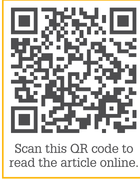
NHG Eye Institute Direct Access Hotline:

NHG Eye Institute is able to accommodate same-day/next day appointments. Depending on the level of care needed and the requested timing, most patients can be seen by an Eye specialist on the same day especially for requests received in the morning. For appointments, GPs should call 6359 6500.



A GUIDE TO BASIC EYE CARE

By **Senior Staff Nurse Jia Lin**, Department of Ophthalmology, Tan Tock Seng Hospital, National Healthcare Group Eye Institute

IN THIS MODERN DIGITAL AGE; MOST PROFESSIONALS FLIT FROM ONE SCREEN TO ANOTHER WHILE GOING ABOUT OUR DAILY TASKS, OR REMAIN FIXATED TO ONE SCREEN FOR PROLONGED PERIODS. MANY OVERLOOK THE NEED TO PAY ATTENTION TO INDIVIDUAL HABITS OF EYE CARE. AS PART OF AN ONGOING SERIES ON EYE CARE BY THE NATIONAL HEALTHCARE GROUP EYE INSTITUTE (NHG EYE INSTITUTE), HERE ARE SOME BASIC POINTERS ON BASIC INDIVIDUAL EYE CARE.

SIMPLE TIPS FOR **EASY EYE CARE**

Recognise the importance of regular and routine eye examinations, and take note of healthy habits to do with using computers.

Take a break: Reduce the strain on your eyes by taking visual breaks. One recommended strategy is the "3-B" approach: blink, breathe and break. For breaks, consider the 20/20/20 rule: For every 20 minutes, look 20-feet away for 20 seconds.

Avoid wearing contact lenses to sleep, which can cause permanent vision damage, as well as extreme discomfort to your eyes.

Always take time to remove your eye makeup before going to bed. If you go to bed with mascara or eyeliner still on, the chemical ingredients may get into your eyes and cause irritation.

Wear Ultraviolet (UV) protective sunglasses when outdoor. Choose sunglasses with a sticker that specifies that the lenses block 99% or 100% of ultraviolet B (UVB) and ultraviolet (UVA) rays.

Always wear goggles in hazardous environments!

Get plenty of sleep. Inadequate sleep may contribute to eye fatigue. Symptoms of eye fatigue include eye irritation, difficulty focusing, dryness or excessive tears, blurred or double vision, light sensitivity, or pain in the neck, shoulders, or back.

By **Adjunct Associate Prof Bernard Thong**, Chairperson, Quality Assurance Committee, Drug & Therapeutics, Tan Tock Seng Hospital
Ms Lim Hong Yee, Head, Pharmacy Department, Tan Tock Seng Hospital

HOW CAN YOUR PATIENTS BENEFIT FROM DRUG SUBSIDIES AND FINANCING SCHEMES?

Chronic Disease Management Programme (CDMP)

CDMP was introduced in October 2006 to help patients reduce the out-of-pocket cash payments for their outpatient bills. Doctors will first have to certify the CDMP-covered ailment or chronic disease, and any medication prescribed must be directly related to the diagnosis for the Medisave amount to be claimable.

EXAMPLE

A prescription for treatment of osteoporosis may include the following:

1. *Risedronate (Actonel®) 35mg once weekly x 12 weeks*
2. *Calcium/Vitamin D 2 tabs om x 12 weeks*
3. *Glucosamine Sulphate 500mg tds x 12 weeks*

Calcium/Vitamin D and Glucosamine Sulphate should not be included as part of the allowable Medisave claims for treatment of osteoporosis. Incidentally, Glucosamine Sulphate cannot be claimed for treatment of osteoarthritis.

Community Health Assist Scheme (CHAS)

The Community Health Assist Scheme (CHAS) provides Singapore Citizens from lower- and middle-income households subsidies for medical and dental care at participating clinics near their homes.

Patients with CHAS card will be eligible for 75% subsidy for Standard List 2 (SDL 2) drugs covered under CDMP. The 75% subsidy is applicable for both inpatient and specialist outpatient medical bills.

EXAMPLE

For a patient on Subsidy Band 1, CHAS scheme will allow greater subsidy for SDL 2 items:

1. *Carvedilol SDL 2 preferred over Nebivolol (Non-standard)*
2. *Venlafaxine (Effexor®) SDL 2 instead of Escitalopram (Lexapro®) (Non-standard)*

Useful References

CDMP Handbook for Healthcare Professionals 2015:
https://www.moh.gov.sg/content/dam/moh_web/HPP/all_healthcare_professionals/Handbook%20for%20Healthcare%20Professionals%20 2015%20%286Aug%29.pdf

Details of MOH Standard List Drugs 2015:
https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/drug_subsidies.html

CME (APRIL – JUNE 2016)

TITLE	CME POINTS	DATE	TIME	VENUE	REGISTRATION DETAILS
Singapore Antimicrobial Stewardship Training Course	Max 8 points	16 & 17 May 2016	8.00am to 5.00pm	Annex 2, Tan Tock Seng Hospital, 11 Jalan Tan Tock Seng, Singapore 308443	For more information and registration, please visit **http://www.ttsh.com.sg/iide**
6th ASEAN Dengue Day Seminar – Featuring other vector borne diseases	Pending; to be advised	18 June 2016	12.00pm to 5.30pm	Holiday Inn Atrium, 317 Outram Road, Singapore 169075	

3 Steps for referring patients to TTSH.

Here's a comprehensive chart listing the steps to refer **non-subsidised patients** and **patients under the Community Health Assist Scheme (CHAS)** to Tan Tock Seng Hospital (TTSH).

To ensure your patients are seen promptly at TTSH, triaging may be conducted by our staff. You may be required to fax referral letter and CHAS cover note to TTSH GP Appointment Hotline or Specialist Outpatient Clinic.

Please retain a copy of the documents for reference purpose.