



# MEMBERSHIP IN GENERAL DENTISTRY TRAINING PROGRAMME 2018-2020

## Programme Content The 4<sup>th</sup> Quarter of 2019 – Module Details

Date & Time	Module Code	Module Topic	Speaker	Duration (Hours)
27 Oct 2019 9:30am - 12:30pm	EDP7 / SDP3*	Dental Practice Inspections - HealthCare Facilities (HCF)	Dr Jerome YU	3
27 Oct 2019 2:00pm - 5:00pm			Dr Simon LIU Chi Yung	3
24 Nov 2019 9:30am - 5:15pm	EDP2 / SDP2*	Medical Emergencies	Dr CHEUNG Koon Ho Ralph Dr KAM Chak Wah Dr TSOI Chun Hing Ludwig Dr WONG Kwun Bun (Specialist in Emergency Medicine)	6
16 Dec 2019 7:00pm - 8:45pm	EDP6 / SDP1*	Practical Considerations for Infection Control in Dental Practice	Dr KUM Chun Sing	1.75

EDP = Essential of Dental Practice (EDP) Modules

SDP = Supervised Dental Practice Program (SDP) Modules

### Supplementary Workshop

Remarks : Lecture topics may be changed subject to the final decision of the CGD.

# MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020

## The 4<sup>th</sup> Quarter of 2019 – Module Details



### *Dental Practice Inspections – HealthCare Facilities (HCF)*

Module Code: EDP7/SDP3

#### *Speaker: Dr Jerome YU*

Specialist in Community Dentistry

BDS (HK), MSc (DPH)(Lond), DDPH RCS Eng, MFGDP (UK), MRACDS (DPH),

FRACDS, FCDSHK (Com Dent), FHKAM (Dental Surgery)

Dr Jerome YU graduated from the University of Hong Kong in 1988. After serving a variety of clinical services in the Dental Service of the Government, Dr Yu was then awarded a government training scholarship and obtained Master of Science in Dental Public Health from the University College London in 2003. Dr YU is now a Senior Dental Officer serving in the Dental Regulatory and Law Enforcement Office (DRLEO) of the Department of Health. He is also a member of the Specialty Board in Community Dentistry of the College of Dental Surgeons of Hong Kong.

Date & Time : 27 October 2019 (Sunday) 9:30 am – 12:30 pm  
Venue : Rooms 903-4, 9/F, HKAM Jockey Club Building,  
99 Wong Chuk Hang Road, Aberdeen, Hong Kong  
Language : English  
CPD Credit : HKDA CPD hours: 3, DCHK CPD points: 3, CDSHK CME points: 3 (Cat A)

### **Synopsis**

Dentists in Hong Kong has been governed and regulated by the Dentist Registration Ordinance (Cap. 156) (DRO) since 1959. Compliance to the DRO are reviewed through routine dental inspection authorized by the Dental Council of Hong Kong. Areas of inspection cover the requirements stipulated in the DRO including the suitability of the premises where the registered dentists practise.

The new Private Healthcare Facilities Ordinance (Cap. 633) (PHFO) has been gazetted on 30 November 2018 which regulates private healthcare facilities (PHFs) namely, hospitals, day procedure centres, clinics and health services establishments under the purview of the Department of Health. Under this new regime, all PHFs are subject to regulation, and the operators will have to apply for licences or letters of exemption, where applicable, such as small practice clinics.

According to the PHFO, different types of PHFs will each be subject to a set of regulatory standards, promulgated in the form of codes of practice, commensurate with the risk of the services they provide. To ensure there is ample time for operators of PHFs to understand and comply with the new regime, the Government will implement the PHFO in phases based on the risk level of various types of PHFs. In order to obtain a licence, the operator of the PHF has to comply with the respective code of practice which covers the governance, staffing, facilities and equipment, service delivery, quality and safety of care, infection control, and other matters related to the operation of these facilities. As this new regime will incur substantial changes in the private dental sector, this lecture aims to provide an astute understanding to this new regime.

**MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020**  
**The 4<sup>th</sup> Quarter of 2019 – Module Details**



***Dental Practice Inspections – HealthCare Facilities (HCF)***

Module Code: EDP7/SDP3

***Speaker: Dr LIU Simon Chi Yung***

Specialist in Family Dentistry

BDS (Syd), MGDSRCS (Edin), FCDSHK (Fam Dent), FHKAM(Dent Surg)

Dr Liu is a specialist in Family Dentistry. He graduated from the University of Sydney, Australia. He obtained Membership in General Dental Surgery from the Royal College of Surgeons of Edinburgh. He is a Fellow of Hong Kong Academy of Medicine and College of Dental Surgeons of Hong Kong. He was appointed as Chairman of Information Technology Committee of Hong Kong Dental Association from 2005 to 2008. Currently, Dr Liu is the Immediate Past Chairman of Specialty Board in Family Dentistry of College of Dental Surgeons of Hong Kong as well as the Immediate Past President of Hong Kong Society of Family Dentistry. He has also been appointed as the Examiner of Membership in General Dentistry of College of Dental Surgeons of Hong Kong since 2015.

Date & Time : 27 October 2019 (Sunday) 2:00 pm – 5:00 pm  
Venue : Rooms 903-4, 9/F, HKAM Jockey Club Building,  
99 Wong Chuk Hang Road, Aberdeen, Hong Kong  
Language : English  
CPD Credit : HKDA CPD hours: 3, DCHK CPD points: 3, CDSHK CME points: 3 (Cat A)

**Synopsis**

Dental practice inspection is to examine MGD candidate whether he/she has the knowledge to establish a good dental practice with sound practice management. Different aspects of practice management such as financial management, risk management, patient information management and operational clinic management will be discussed in the lecture to ensure MGD candidate fully understands the principles of practice management.

**MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020**  
**The 4<sup>th</sup> Quarter of 2019 – Module Details**



**\*MEDICAL EMERGENCIES\***

***Patient Assessment and Neurological System***

Module Code: EDP2/SDP2

***Speaker: Dr CHEUNG Koon Ho Ralph***

Specialist in Emergency Medicine

MBChB, FHKCEM, FHKAM (Emergency Medicine), MScHSM (CUHK)

Dr Cheung is a Specialist Emergency Physician. He was graduated in the Chinese University of Hong Kong. He is currently a consultant in Accident and Emergency Department of Prince of Wales Hospital, and honorary clinical associate professor in A&E Medicine Academic Unit, the Chinese University of Hong Kong.

He has been actively teaching various popular courses relating to emergency care, especially resuscitation, emergency ultrasound, and medical simulation. He is an examiner for Hong Kong College of Emergency Medicine, a training supervisor for department trainees, and an associate editor of Hong Kong Journal of Emergency Medicine.

**Synopsis**

**Patient assessment** involves targeted history, physical examination and appropriate bedside monitoring equipment or investigations.

In emergency situations, provided scene safety, key to handling involves awareness of acute event, appropriate assessment of airway, breathing, circulation, disability, and work out differential diagnoses. Vital signs such as blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation are very useful. “AMPLE” history (allergies, medications, past medical history, last meal, event) and “head to toe examination” are often quoted patient assessment tools.

**For neurological system**, there would be a brief recap on central and peripheral nervous system. Causes, clinical features, differential diagnosis and managements of various neurological conditions (syncope, convulsion, stroke) would be discussed.

**MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020**  
**The 4<sup>th</sup> Quarter of 2019 – Module Details**



**\*MEDICAL EMERGENCIES\***

***Endocrine Emergency – Clinical Pearls & Pitfalls  
for Dental Practitioners***

Module Code: EDP2/SDP2

***Speaker: Dr KAM Chak Wah***

Specialist in Emergency Medicine

Dr Kam is a medical graduate of The University of Hong Kong (HKU). He has obtained the higher qualifications in Emergency Medicine, General Surgery and Internal Medicine of the British & HK Colleges. He has taken intensive overseas training in North America.

He has served in numerous public hospitals in the capacity of EM Consultant, Clinical Skills Director & Trauma Committee Chairman as well as visiting professor & external examiners of numerous overseas countries.

In the past 2 decades, he has substantially contributed to EM Service Modernization, Subspecialty establishment, new Inter-specialty Patient Management Protocols (including but not limited to Trauma Team establishment), Clinical Staff T&D in both EM & Holistic Clinical Skills (with annual participants of more than 1000 staff).

Besides, he is not only the Founder Editor-in-chief in 1994 of the HK Journal of Emergency Medicine, but also the Founder Chairman of the Examination Committee of the HK College of Emergency Medicine in 1996.

He has over 100 publications including journal articles and book chapters covering resuscitation, trauma, toxicology, USG, domestic violence and administration. His latest academic products include a 70-case graphic book entitled Clinical Quiz in Emergency Medicine, Injury Review Papers on Ten Commandments in Polytrauma (WJEM 2010), Exsanguinating Pelvic Fracture (HKJEM 2019), a Book Chapter on Domestic Violence Management in ED & Reversal for New Oral Anti-coagulant (NOAC in New England J Med 2017). His recent academic lectures include, but not limited to, Rescue Strategy for Tragic Pelvic Disruption & Pitfalls in Emergency Imaging.

His subspecialty interest is in Resuscitology, Traumatology, Clinical Simulation Training & Emergency Diagnostics.

## **Synopsis**

### **Introduction**

The endocrine system consists of ductless glands that produce & release hormones directly into the blood stream. The hormones regulate, but not limited to, growth, development, metabolism, homeostasis, sexual / reproductive function, mood, sleep and to maintain homeostasis and to meet the stress or demand of the daily activities.

The major human endocrine organs comprises of the pituitary, thyroid, parathyroid, pancreas, adrenal & sexual gonads (testes & ovaries).

Endocrine dysfunctions of the thyroid, pancreas & adrenal gland can cause occult or overt clinical neurological manifestation from agitation, impaired sensorium to coma and cardio-vascular instability with potential lethal outcome if not timely recognized & promptly treated.

### **1) Thyroid Storm**

Thyroid storm (Thyrotoxic Crisis) is an abrupt, life-threatening, hypermetabolic derangement triggered by excessive release of thyroid hormones (THs) in usually in thyrotoxic subjects. The clinical features encompass fever, tachycardia, severe hypertension, neurological and GI aberration.

Diagnosis is primarily clinical, and no immediate POCT or specific laboratory tests are available since TFT usually takes hours or days to obtain the results. Several factors may precipitate the progression of thyrotoxicosis to thyroid storm including Sepsis, Surgery, Anesthesia induction, Radioactive iodine (RAI) therapy, Drugs (anticholinergic and adrenergic drugs, salicylates, NSAID, chemotherapy) & Withdrawal of or Noncompliance with Anti-thyroid medications.

Treatment comprises of Critical supportive measures to maintain the hemodynamics and rapid cooling for hyperthermia, Antiadrenergic drugs, Thionamides, Iodine preparations, Glucocorticoids, Bile acid sequestrants, treatment of the underlying condition & very uncommonly Plasmapheresis. If untreated, thyroid storm is almost highly fatal of 90% mortality rate. Death from thyroid storm may be a consequence of cardiac arrhythmia, congestive heart failure, hyperthermia, multiple organ failure or other factors, though the precipitating factor is often the cause of death.

### **2) Hypothyroidism – Myxoedema Coma or Crisis**

Myxedema denotes severe hypothyroidism & also the dermatologic changes that occur in hypothyroidism and occasionally hyperthyroidism (pretibial myxedema) with dermal deposition of mucopolysaccharides leading to the abnormal cutaneous swelling.

The condition usually chronic in patients with undiagnosed hypothyroidism complicated with physiological decompensation usually due to infection, CVA, CHF, trauma or drug therapy. Patients with myxedema coma are generally critically-ill with impaired consciousness & significant hypothermia.

Myxedema coma requires immediate treatment in a critical care unit with intensive cardiac monitoring. Initial management includes airway management, supportive measures, thyroid hormone replacement & glucocorticoid therapy.

Any delay in Dx & Rx may be associated with a high mortality rate of more than 50%. Even with immediate recognition and timely medical intervention, mortality rates are still very substantial of up to 25%. The most common causes of death are respiratory failure, sepsis, and gastrointestinal bleeding.

### **3) Diabetic with Acute Hypoglycemia**

Prehospital care commonly consists of finger prick blood sampling with POCT glucometer assay if available prior to administering IV D50 solution for adult patients with impaired sensorium. Conscious but symptomatic patient may be treated with oral glucose water.

Because the brain uses glucose as its primary energy source, treatment procrastination will lead to detrimental neuronal damage. Hence, glucose replacement may be commenced based on clinical judgement even if POCT test is not available. Even if the diagnosis is incorrect, a hyperglycemic patient with an altered mental status may receive the glucose bolus without significant harm.

The initial approach in the ED should include the following:

- Primary survey (ABCDE) with simultaneous resuscitation
- Intravenous (IV) access
- Oxygen
- Monitoring
- POCT glucose monitoring
- Management of hypoglycemic convulsion if occurs

Once the diagnosis of hypoglycemia in the diabetic is made, it is essential to evaluate of the potential causes of the hypoglycemic episode include medication changes, wrong insulin injection technique, dietary changes, new metabolic changes including aggravating renal function, recent illness, and occult infection.

### **4a) Diabetic Ketoacidosis (DKA)**

DKA is an abrupt, major, life-threatening complication of diabetes that mainly occurs in patients with type 1 diabetes (insulin-dependent), but it is not uncommon in some patients with type 2.

Typical DKA features are hyperglycemia, ketoacidosis, and ketonuria. It occurs when absolute or relative insulin deficiency inhibits the ability of glucose to enter cells for utilization as metabolic fuel. Consequently, the liver rapidly metabolizes fat into ketones as the energy supply. The excessive production of ketones leads to accumulate in the blood and urine & subsequently the acidemia.

Treatment includes aggressive but controlled correction of fluid loss with intravenous fluids; gradual correction of hyperglycemia with insulin by continuous IV infusion; correction of electrolyte disturbances, particularly dyskalemia; correction of acidosis; & Rx of concurrent infection (if present) in a critical care unit.

The overall mortality rate for DKA is 0.2-2%. The presence of deep coma at the time of diagnosis, hypothermia, and oliguria are signs of poor prognosis. The prognosis of properly treated patients with diabetic ketoacidosis is very positive, especially in younger patients if intercurrent infections are absent. The worst prognosis usually is observed in older patients with severe intercurrent illnesses (eg, myocardial infarction, sepsis, or pneumonia), especially when these patients are treated outside an intensive care unit.

Cerebral edema remains the most common cause of mortality, particularly in young children and adolescents. Cerebral edema frequently results from rapid intracellular fluid shifts. Other causes of mortality include severe hypokalemia, adult respiratory distress syndrome, and comorbid states (eg, pneumonia, acute myocardial infarction).

#### **4b) Diabetic Hyperosmolar Hyperglycemic State (DHHS)**

DHHS is 1 of 2 serious life-threatening metabolic complications of DM. It is less common than DKA but carries a much higher mortality rate, reaching up to 5-10%.

DHHS was previously termed diabetic hyperosmolar hyperglycemic non-ketotic coma (DHHNC); however, the terminology has been revised because coma is found in fewer than 20% of patients with HHS.

HHS is most commonly seen in patients with type 2 DM who have some concomitant illness that leads to reduced fluid intake. It typically occurs in elderly institutionalized persons with decreased thirst perception and reduced ability to drink water. Infection is the most common preceding illness, but many other conditions, such as CVA & AMI can be the aetiology.

HHS is characterized by hyperglycemia, hyperosmolarity & dehydration without significant ketoacidosis. Most patients present with severe dehydration and focal or global neurologic deficits. The clinical features of HHS and DKA overlap and are observed simultaneously (overlap cases) in up to one third of cases.

Detection and treatment of an underlying illness are critical. Standard care for dehydration and altered mental status is appropriate, including airway management, intravenous (IV) access, crystalloid administration, and any medications routinely given to coma patients. Although many patients with HHS respond to fluids alone, IV insulin in dosages similar to those used in DKA can facilitate correction of hyperglycemia. Insulin used without concomitant vigorous fluid replacement increases the risk of shock.

#### **5) Adrenal Crisis – Life-threatening Hypoadrenalism / Addisonian Crisis**

Adrenal crisis is a dire medical condition owing to acute insufficiency of the cortisol & aldosterone hormones. This may be the result of either previously undiagnosed or untreated Addison's disease, a disease process suddenly affecting adrenal function (such as bleeding from the adrenal glands in Waterhouse-Friderichsen syndrome due to fulminant meningococemia & anticoagulation complications), acute cessation of glucocorticoid replacement or an intercurrent stress (e.g. infection, trauma, in fact any form of physical or mental stress) in Addison's disease patients, congenital adrenal hyperplasia (CAH), or other form of primary adrenal insufficiency.

Adrenal crisis is often elusive, which may result in severe morbidity and mortality when undiagnosed or ineffectively treated.

Glucocorticoids are nonspecific cardiac stimulants that activate release of vasoactive substances. In the absence of corticosteroids, stress results in hypotension, shock, and death. Glucocorticoids also stimulate gluconeogenesis, decrease cellular glucose use, antagonize the insulin actions & exhibit anti-inflammatory effects.

Aldosterone is produced by hydroxylations of deoxycorticosterone & is normally 60% protein bound. The renin-angiotensin system stimulates aldosterone release. The primary actions of aldosterone cause the kidneys, gut, and salivary/sweat glands to maintain electrolyte balance. In the kidneys, aldosterone stimulates reabsorption of sodium and secretion of potassium and hydrogen ions.

Emergency department care includes the following:

- Maintain airway, breathing, and circulation in patients with adrenal crisis
- Use coma protocol (ie, glucose, thiamine, naloxone)
- Use aggressive volume replacement therapy (D5NS)

- Correct electrolyte abnormalities as follows:
  - Hypoglycemia, Hyponatremia, Hyperkalemia & Hypercalcemia
- Use dextrose 50% as needed for hypoglycemia.
- Administer hydrocortisone & fludrocortisone
- Treat the underlying problem that precipitated the crisis. Infectious etiologies commonly precipitate adrenal crisis. Recognition and treatment of causative factors are crucial aspects of managing critical adrenal hypofunction.

## **6) Pheochromocytoma**

Owing to the excessive catecholamine secretion, pheochromocytomas may precipitate life-threatening hypertension or cardiac arrhythmias. If the diagnosis of a pheochromocytoma is overlooked, the consequences can be tragic with ensuing death. On the other hand, it is potentially curable.

## **7) Insight & Medico-Dental Collaboration**

Endocrine dysfunction or emergency may or will respectively contra-indicate elective dental procedures. On the other hand, endocrine emergency might be triggered by dental operation with local or general anaesthesia inducing significant body stress.

Careful history evaluation, relevant physical examination & concerted collaboration with relevant medical practitioners can assist dental specialists to discern the endocrine abnormality from subclinical / occult to overt status to obtain the prior medical therapy to stabilize or optimize the deranged physiology to enable the dental surgeons to perform the essential urgent OMF intervention to reduce mortality & to maximize the patient outcome or the dentists to plan the elective procedures.

## **8) Pharmaco-vigilance – Drug Side-effects / Anaphylaxis & Impact of Anti-platelet & Anti-coagulant Agents to Dental Procedures**

### **a) Drug-induced Anaphylaxis**

Dental treatment may involve analgesic (including NSAID), anti-infective agents & local anaesthetic (commonly the lignocaine) which may cause allergic reaction or in the severe form of life-threatening anaphylaxis comprising of anaphylactic shock, laryngeal edema & bronchospasm. The prompt recognition with rapid resuscitative ABC treatment coupled with the parenteral adrenaline administration are the most essential treatment. Subsequent therapy with corticosteroid and anti-histamines (H1 & H2 blockers) are necessary. Beware of the biphasic anaphylactic reaction which can cause relapse of the anaphylaxis phenomenon after a period of quiescence.

### **b) Anti-platelet Agents – Impact to Dental Procedures**

Owing to rising incidence of Ischemic Heart Disease & PCI (Percutaneous Coronary Intervention) and Ischemic Cerebral Infarct, anti-platelet agent use (aspirin & clopidogrel) are often encountered in the elder patients. If local hemostatic measures (gauze, hemostatic agent, sutures) can readily be applied, the common dental procedures from scaling, RCT, extraction to implant can be performed without withholding the anti-platelet agents.

Despite the past controversy of “Bleed or Die” (Bleed – continuation of anti-platelet agent causes more Bleeding & Die – stopping anti-platelet agent leads to coronary or cerebral arterial thrombosis resulting in Death), the latest research & consensus opinions favour continuation of the anti-platelet agents.

### **c) Warfarin – Impact to Dental Procedures**

For elective procedures, the INR must be achieved to within the safe range before operation. For emergency dento-facial surgery, Vit K, FFP / PCC (Prothrombin Complex Concentrate) are utilized to attain rapid clotting control.

### **NOAC / DOAC (New or Direct Oral Anti-coagulant) – Impact to Dental Procedures**

There is no strong direct evidence to guide on the continuation or omission of the NOAC prior to dental procedures. Consensus opinion favours continuation for minor or non-invasive procedures. As for the high-risk or invasive procedures, omission in the morning is advised for the normal renal function patients. For patients with impaired renal functions, longer period of drug omission is required for the clearance. Certainly, the dental surgeon & medical doctor concerned should provide the PROs (bleeding control) & CONS (thrombosis risk) of drug omission in the informed consent to involve the patient in the choice.

For emergency dento-facial procedures to control bleeding, specific anti-dote is available to reverse the dabigatran effect, and FFP & PCC (Prothrombin Complex Concentrate) can be used for other NOAC.

### **Visionary Partnership**

Once again, the seamless collaboration between the dental & medical practitioners are essential to attain a safe operation condition to reduce bleeding & to prevent re-thrombosis to maximize the patient outcome !

## MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020

### The 4<sup>th</sup> Quarter of 2019 – Module Details



#### **\*MEDICAL EMERGENCIES\***

#### ***Cardiovascular System Emergencies***

Module Code: EDP2/SDP2

#### ***Speaker: Dr TSOI Chun Hing Ludwig***

Specialist in Emergency Medicine

Dr Ludwig Tsoi is the Consultant of A&E Department of Queen Mary Hospital. He is also the President of the Hong Kong Society for Emergency Medicine & Surgery, and the Honorary Secretary of the Hong Kong College of Emergency Medicine. He has made significant contribution to the collaborative developments in Emergency Medicine in Greater China region. He also possesses abundant experience in mediation practice and hospital management. Currently he is Deputy Service Director of Quality & Safety Department of Hong Kong West Cluster, Hospital Authority.

#### **Synopsis**

The cardiovascular diseases (CVD) are the number 1 cause of death globally, and the coronary heart disease accounts for the majority of cardiovascular death. People with established CVD or high risk factors for CVD needs early detection of symptoms related to CVD, especially chest pain and dyspnea, for prompt management and prevention of life-threatening complications such as cardiogenic shock and sudden cardiac arrest. However, sudden cardiac arrest may be the first presentation of the CVD.

The lecture will include several potentially life-threatening cardiovascular diseases and its management. The “chain of survival” for sudden cardiac arrest will be discussed because the survival for sudden cardiac arrest is highly time-dependent. Shock state, as defined by inadequate blood perfusion to tissues resulting in tissue hypoxia, will also be discussed in the lecture.

**MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020**  
**The 4<sup>th</sup> Quarter of 2019 – Module Details**



**\*MEDICAL EMERGENCIES\***

***Respiratory Emergencies***

Module Code: EDP2/SDP2

***Speaker: Dr WONG Kwun Bun***

Specialist in Emergency Medicine

MBBS(HK), FHKCEM, FHKAM (Emergency Medicine), DFM(CUHK),

PgDipPD (Cardiff), DCH(Sydney)

Dr Wong Kwun Bun is a specialist in Emergency Medicine and is currently working as Associate Consultant at Princess of Wales Hospital. Dr Wong is also Honorary Clinical Assistant Professor of the Chinese University of Hong Kong. He is involved in teaching, research, and various Emergency Medicine-related activities. His special interest is toxicology and hyperbaric medicine. He is a Council member and the Vice chairperson of Internal Affairs of the Hong Kong Society for Emergency Medicine and Surgery.

**Synopsis**

Respiratory problem is one of the main Emergency encountered in Emergency Department. Through different case scenario, students will be able to recognize the clinical presentation and master the basic management of common respiratory emergency problem. Student will be able to utilize the assessment findings to formulate diagnosis and implement the treatment plan for the patient with respiratory emergencies.

- Date & Time : 24 November 2019 (Sunday) 9:30 am – 5:15 pm  
 Venue : Function Room 1, 2/F, HKAM Jockey Club Building,  
 99 Wong Chuk Hang Road, Aberdeen, Hong Kong  
 Language : English  
 CPD Credit : HKDA CPD hours: 6, DCHK CPD points: 6, CDSHK CME points: 6 (Cat B)  
 Schedule : Please refer to the table below :

24 November 2019 (Sunday)	
9:00am – 9:30am	Registration for Speakers, Chairperson and Trainees/Participants
9:30am – 11:00am	Patient Assessment and Neurological System (by Dr Cheung Koon Ho Ralph)
11:00am – 11:15am	Tea break
11:15am – 12:45pm	Respiratory Emergencies (by Dr Wong Kwun Bun)
12:45pm – 2:00pm	Lunch break
2:00pm – 3:30pm	Cardiovascular System Emergencies (by Dr Tsoi Chun Hing Ludwig)
3:30pm – 3:45pm	Tea break
3:45pm – 5:15pm	Endocrine Emergencies and Clinical Pearls & Pitfalls for Dental Practitioners (by Dr Kam Chak Wah)

**MEMBERSHIP IN GENERAL DENTISTRY (MGD) TRAINING PROGRAMME 2018-2020**  
**The 4<sup>th</sup> Quarter of 2019 – Module Details**



***Practical Considerations for Infection Control  
in Dental Practice***

Module Code: EDP6/SDP1

***Speaker: Dr KUM Chun Sing***

Specialist in Family Dentistry

BDS (HK), MGDS RCS (Edin), FRACDS, FCDSHK (Family Dentistry),

FHKAM (Dental Surgery)

Dr Kum graduated from the University of Hong Kong in 1988. After working as a general dental practitioner for three years, he joined the Hospital Authority as a Hospital Dental Officer in 1992. He obtained his MGDS, RCS(Edin) in 2000 and FRACDS in 2003, and was conferred Fellowships of FCDSHK (Family Dentistry) and FHKAM (Dental Surgery) in the same year. Dr Kum is the Deputy Chairman of the Specialty Board of Family Dentistry and the Hon Secretary of the Hong Kong Society of Family Dentistry. He is now working in the Department of Dentistry & Maxillofacial Surgery of the United Christian Hospital.

Date & Time : 16 December 2019 (Monday) 7:00 pm – 8:45 pm  
Venue : Function Room 2, 2/F, HKAM Jockey Club Building,  
99 Wong Chuk Hang Road, Aberdeen, Hong Kong  
Language : English  
CPD Credit : HKDA CPD hours: 2, DCHK CPD points: 2, CDSHK CME points: 2 (Cat A)

**Synopsis**

The risk of cross infection has always existed in dental treatment. Dental health professionals have a duty to take appropriate precautions to protect patients and other members of the dental team from that risk. The lecture aims to discuss fundamental concept of infection control measures in a dental surgery from a practical perspective.