



<b>Title</b>	<b>Movement disorder clinic registry at Tung Wah Hospital</b>
<b>Author(s)</b>	<b>Tsang, TKL; Ho, SL</b>
<b>Citation</b>	<b>The 3rd Medical Research Conference (MRC 1998), Hong Kong, China, 10-11 January 1998. In The Hong Kong Practitioner, 1998, v. 20 n. 2 suppl., p. 19</b>
<b>Issued Date</b>	<b>1998</b>
<b>URL</b>	<b><a href="http://hdl.handle.net/10722/46797">http://hdl.handle.net/10722/46797</a></b>
<b>Rights</b>	<b>Creative Commons: Attribution 3.0 Hong Kong License</b>

## **Movement Disorder Clinic Registry at Tung Wah Hospital**

**K.L. Tsang and S.L. Ho**

The patient profile of the Movement Disorder Clinic in Tung Wah Hospital was reviewed. Case records (n=611) were reviewed and 427 patients attended the clinic at least once within the past year, up to October 1997. Idiopathic parkinsonism was the most common diagnosis, comprising 76% of the population, followed by essential tremor (8%), secondary parkinsonism (6.3%), vascular pseudoparkinsonism (4.0%), and the rest including chorea, myoclonus and dystonia. Amongst the idiopathic parkinsonism group of patients, 269 patients had typical clinical features of the disease (triad of tremor, rigidity and bradykinesia); 56 patients with either probable or possible disease. Postural instability, another diagnostic criteria, was present less frequently (29.1%). For the clinically typical cases, the mean age of onset of symptoms was 61.2 years, mean age was 68.1 years, male:female ratio was 1.2:1. Of these patients, 3.7% was regarded as young-onset (before 40-year-old).

Motor fluctuation was found in 22.3%. Patients of younger age of onset were noted to have motor fluctuation earlier (linear regression,  $p=0.008$ ). Psychiatric features (including hallucination, dementia and depression) were found in 9.2% of the patients and their mean duration of disease was 10.1 years. The patients with vascular pseudoparkinsonism (n=17) had quite different profile. Their mean age was 71.2 years and the duration of disease was 4.2 years. Commonest symptom among them was bradykinesia (88.2%) and tremor was seldom seen (11.8%).

35 patients with essential tremor were identified. Their mean age was 64 and the male to female ratio was 0.9 to 1. The mean age of onset was 52.

## **MORTALITY AND MORBIDITY OF STATUS ASTHMATICUS: A RETROSPECTIVE ANALYSIS**

**Jane C. K. Chan, W. K. Lam**, Department of Medicine, Queen Mary Hospital

**Introduction:** Patients (pts) presenting with an acute severe asthmatic attack are at risk of a life-threatening illness which may result in death. We retrospectively reviewed ICU pts with status asthmaticus (SA) for a better understanding of the M & M associated with SA, which will hopefully be translated into better pt service.

**Method:** All ICU pts between 1/1995 and 9/1997 with an ICU admission diagnosis of asthma were retrospectively identified. Their medical records were reviewed. Non-parametric t-test corrected for small sample size was used for statistical analysis.

**Results:** 21 pts with 22 episodes of confirmed SA were identified. In 12 episodes, the pts were immediately intubated at A & E because of out-of-hospital arrest (1), unrecordable blood pressure (3), and altered sensorium with recordable blood pressure (9). Of the remaining 10 episodes, 8 required intubation because of worsening respiratory status, either within a few hours of hospital admission (3), or during subsequent hospital days (5). Of the 5 pts in the last group, 2 had in-hospital CPR before ICU admission. Among the 19 pts who were intubated before ICU admission, the delay between intubation and ICU admission was 7.5 hrs (range 1-31 hrs), during which period 4 pts developed ventilator-related complications, one leading to CPR. A total of 4 deaths (18.2% mortality) were identified, all arising from pre-ICU anoxic insult, among whom 3 were arrest victims. ICU morbidity appears to be substantial in those pts requiring longer ventilator days.

**Conclusion:** (1) Asthma deaths arise mainly from anoxic insult during the hyperacute stage. Pt awareness and education coupled with prompt expert medical intervention before the onset of anoxia may potentially avert asthma deaths. (2) Morbidity in these pts arises from (a) ventilating these pts in an unmonitored setting, and (b) prolonged mechanical ventilation. Such morbidities can be avoided if proper monitoring is provided promptly and/or if prolonged sedation and paralysis are reserved for those with refractory SA.