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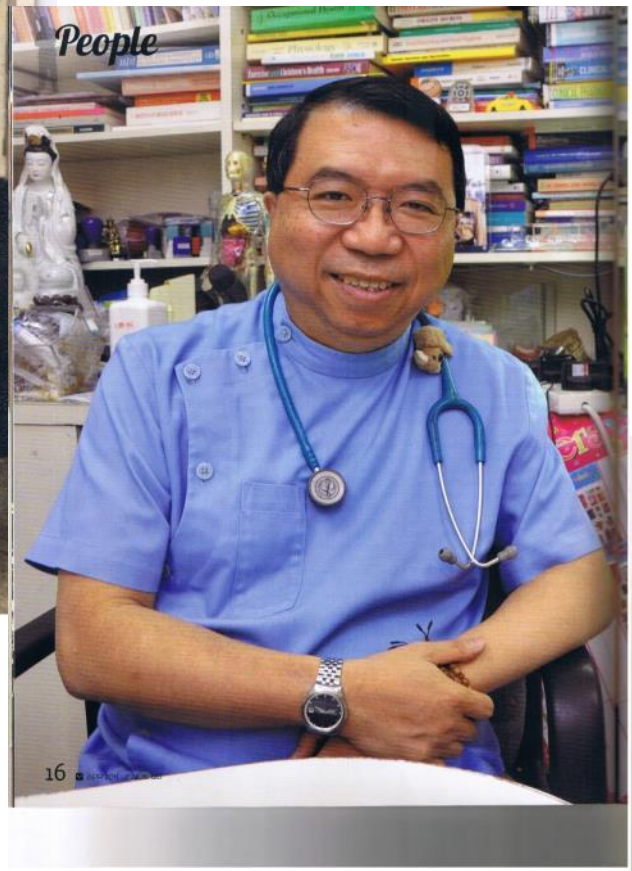
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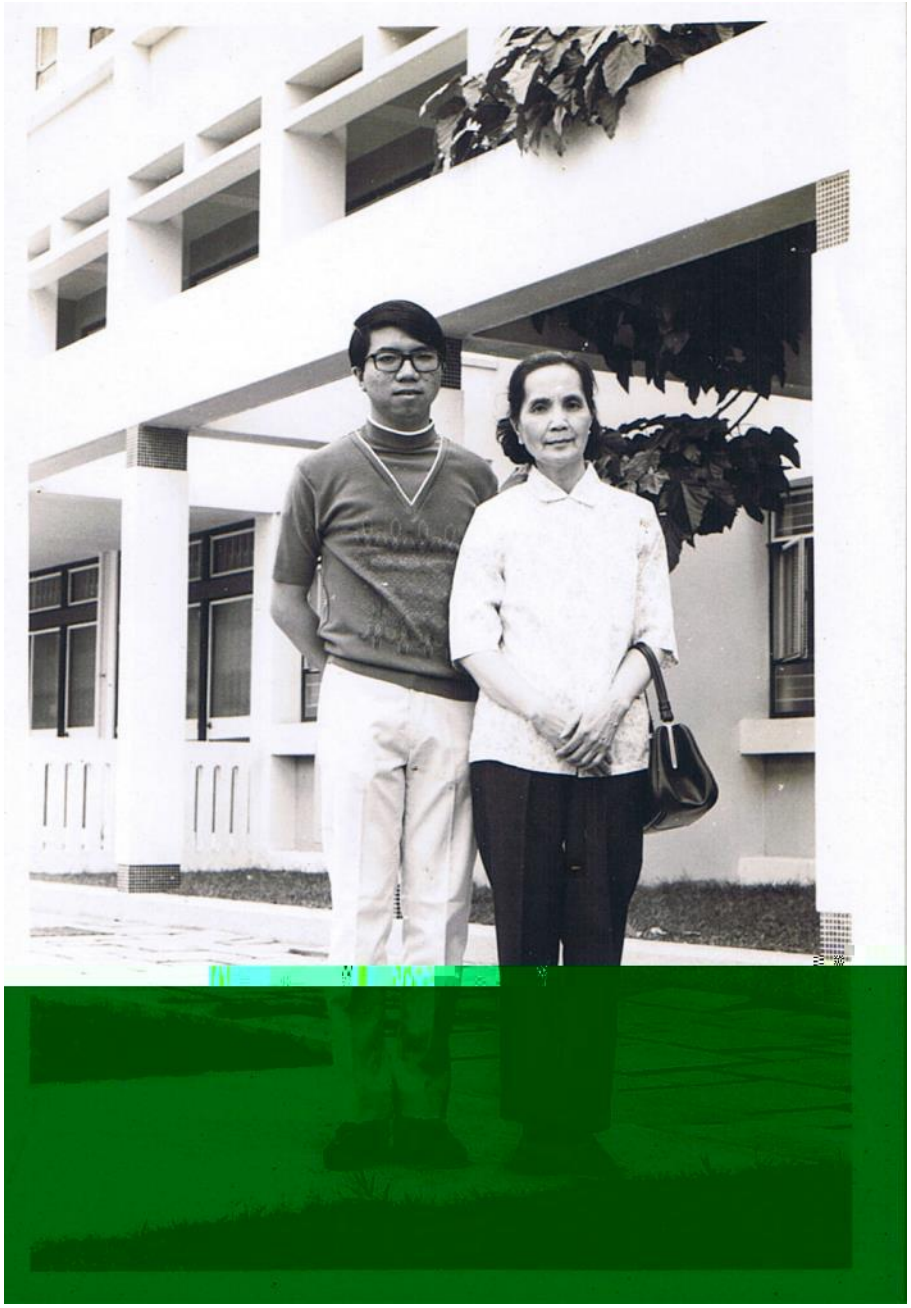

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尚附設

本校附屬小學校門

下午小學五年級乙班

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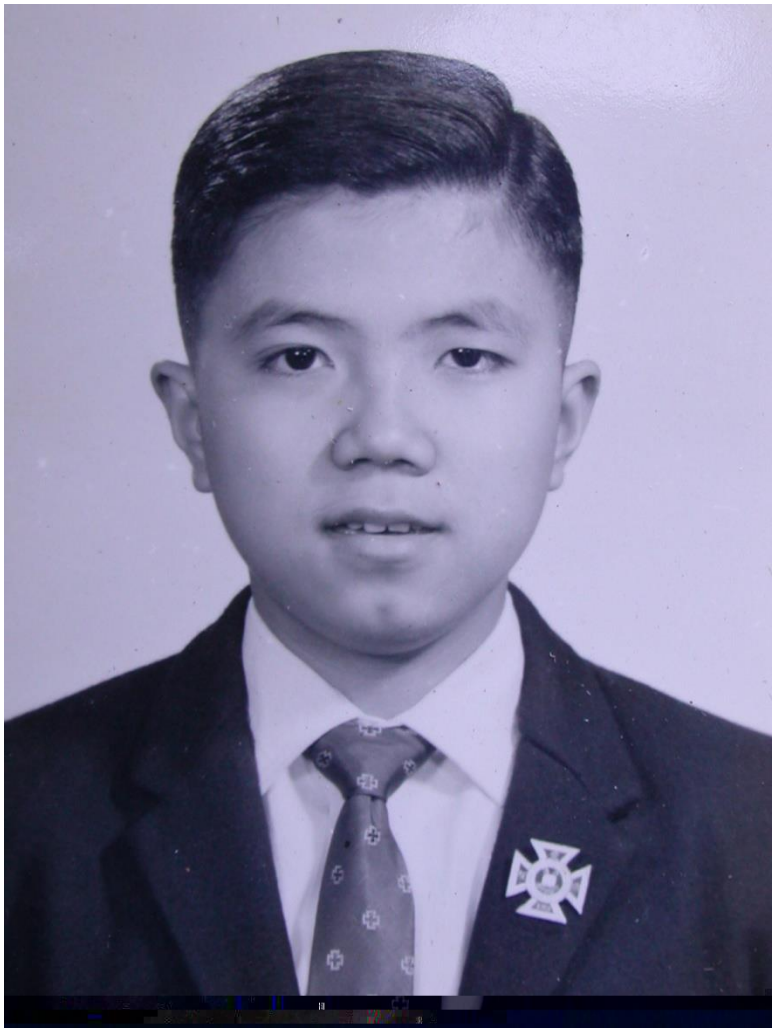


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100
在禮堂表演

INFECTION PREVENTION

Vaccines:

Prevnar 13

Haemophilus Influenzae b (Hib)

Rotavirus

Chickenpox

Meningococcal

ASCARIS LUMBRICOIDES (ROUNDWORM)

Incidence

Ascaris lumbricoides is one of the commonest human parasitic infections worldwide. It is not common in the UK.

Aetiology

Larvae hatched from ingested eggs enter the venous system and migrate through the lungs to the oesophagus. Fertilized eggs from adult worms in the intestine are passed with faeces to contaminate soil; the cycle recurs when they, in turn, are ingested.

Diagnosis

Most infected people are symptom-free. Respiratory symptoms (cough, wheeze), fever and eosinophilia occur during the pulmonary phase. Anorexia, abdominal cramps and even intestinal obstruction may occur with heavy infestation. Worms can migrate to obstruct the biliary system (causing jaundice), pancreatic ducts (causing pancreatitis), appendix (causing appendicitis), and lead to volvulus, intussusception, intestinal perforation and peritonitis. The faeces should be examined microscopically for ova and adult worms, and sputum and gastric washings should be used to detect larvae.

Treatment

Mebendazole, albendazole, flubendazole or piperazine. Endoscopy to relieve biliary and pancreatic duct obstruction. Intestinal obstruction may be relieved by antihelminthic drug with intravenous fluids and nasogastric suction, but surgery may be necessary.

ENTEROBIUS VERMICULARIS (THREADWORM) (9.42)

Incidence

Most common in temperate and cold climates but also occurs worldwide. Particularly affects children, but may be transmitted to other family members.

Diagnosis

Anal pruritis, particularly at night when the adult female lays eggs in the perianal region. Rarely, other symptoms may develop; for example, symptoms of appendicitis when worms enter the appendix lumen or if adult worms migrate through the intestinal wall to invade other organs. The 'Sellotape test' involves placing a piece of clear adhesive tape over the perianal region at night, then removing it in the morning and examining it for small white specks/ova.

Treatment

Mebendazole is the drug of choice (except for children under 1 year of age, for whom it is not recommended), or piperazine. The whole family should be treated and treatment repeated two to four weeks later to eradicate any worms hatched since first treatment.

9.42 *Enterobius vermicularis* (threadworm) seen on colonic mucosa at colonoscopy.


13/11/2013

Allergic and vasomotor rhinitis

The term 'rhinitis' implies an inflammatory response of the lining membrane of the nose and may be intermittent or persistent. It is important to understand that such an event can occur as a consequence of both primary allergic and non-allergic mechanisms (Fig. 1). In allergic rhinitis, specific allergens are responsible for a type 1 hypersensitivity reaction, and the symptom complex may be subclassified as being predominantly seasonal or perennial. Non-allergic pathologies include viral and bacterial infections (pp. 38, 50), as well as autonomic nervous system abnormalities which can result in vasomotor rhinitis.

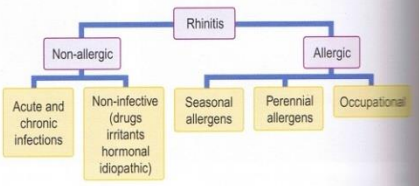


Fig. 1 **Causes of rhinitis.**

Allergic rhinitis

Between 10 and 20% of the population suffer to some degree from nasal manifestations of an antigen–antibody type 1 hypersensitivity reaction (Fig. 2). In seasonal allergic rhinitis (hay fever), the allergens are inhaled, e.g. grass, pollens, weeds and flowers. Animal dander, household dust, the dust mite and feathers are the principal allergens in perennial allergic rhinitis and have no seasonal variation. Rarely, ingested allergens are implicated in the perennial group, e.g. dairy products and wheat.

Clinical features

The clinical features of allergic rhinitis include the classic triad of:

- nasal obstruction due to mucosal vasolidation and oedema
- rhinorrhoea (runny nose) due to enhanced activity of glandular elements
- paroxysms of sneezing due to mucosal stimulation.

The symptom complex is produced by allergen binding to immunoglobulin E (IgE), which in turn is bound to mast cells. This causes degranulation of mast cells and the release of mediator substances such as histamine, leukotrienes and SRSA.

Many patients have associated evidence of atopy such as asthma, eczema, allergic dermatitis and drug allergies. Aspirin sensitivity is not infrequent. Taking a detailed clinical history may identify the allergens involved.

Typically, the nasal mucosa has a boggy, oedematous appearance (Fig. 3); it is covered by a thin layer of watery secretion. Application of a vasoconstrictor produces marked mucosal shrinking with improvement in the nasal airway. Skin-prick tests

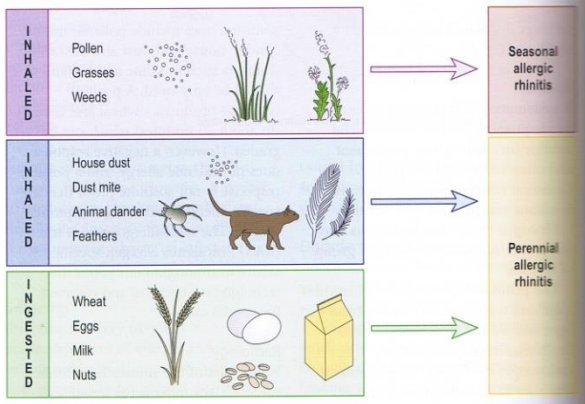


Fig. 2 **Common allergens in allergic rhinitis.**

should be interpreted only in relation to the history. Negative skin tests in the face of obvious allergens are not infrequent.

Management

The simplest treatment is avoidance of known allergens. In perennial allergic rhinitis, the quantity of dust and dust mite may be reduced in the bedclothes by:

- changing a feather pillow to foam
- washing the bedclothes twice weekly, as the antigen is heat sensitive

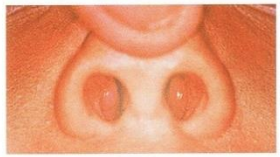
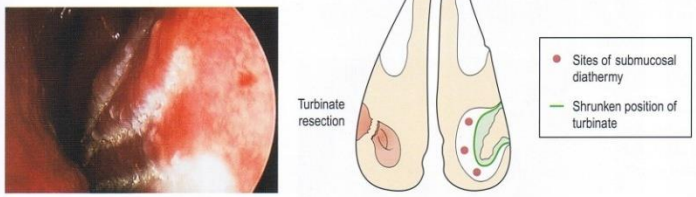


Fig. 3 **Oedematous inferior turbinates narrowing the nasal airway in a patient with hay fever.**

- using commercial sprays that inhibit house dust mite
- using a dust proof cover over the mattress, duvet and pillows
- avoiding carpets and heavy drapes in the bedroom.

Suspected food allergens may be excluded from the diet or replaced with suitable alternatives. Removing animal dander by giving up a pet may be emotionally upsetting but necessary.

Desensitization injections may be offered. These work on the principle of producing a blocking IgG antibody that prevents antigen binding to IgE. Obviously, the treatment is only of value if specific allergens can be identified, and it is essential to commence the series of necessary injections well in advance of the exposure. Due to the risk of anaphylaxis, desensitization must be done in a controlled environment with adequate resuscitation available.



(a) (b)

Fig. 4 **(a) Endoscopic photograph of turbinate after laser reduction. (b) Resection and submucosal diathermy of inferior turbinates to relieve obstruction.**

Drug therapy

Therapy involving the use of both topical and systemic drugs has been directed at either preventing mast cell degranulation or blocking the effect of released mediators.

Topical sodium cromoglycate stabilizes the mast cell membrane and prevents the release of chemical agents. It has provided effective relief of asthmatic symptoms but has been less successful in allergic rhinitis. Local decongestants can be either sympathomimetic agents or steroids. The former group includes ephedrine nose drops which provide dramatic shrinkage of nasal mucosa, but long-term use can lead to rhinitis medicamentosa. Locally-acting steroid nasal sprays, e.g. beclometasone, fluticasone, are highly effective against blockage and rhinorrhoea. Regular use in a 'course' is important. Topical antihistamines are an alternative.

Systemic drug therapy includes antihistamines which act by blocking the H_1 nasal mucosa receptors. Their major drawback is drowsiness. Modern derivatives are less able to cross the blood–brain barrier, hence reducing side-effects. If sedation occurs, medication can be taken at night.

Surgery

Surigical treatment (Fig. 4) is only infrequently indicated, as most patients' symptoms are controlled by conservative therapy. Turbinate resection, cautery or outfracture may improve nasal obstruction, but rhinorrhoea and sneezing are unaffected by surgical manipulations.

Intrinsic rhinitis (vasomotor rhinitis)

Intrinsic rhinitis is common (10–15% of the population). The symptoms are similar to allergic rhinitis with less sneezing, and the patient does not have positive allergy testing results. The pathophysiology involves an imbalance between the parasympathetic and sympathetic autonomic nerve supply of the nasal mucosa. The former predominates causing nasal obstruction due to increased vascularity. Enhanced mucosal secretion produces watery rhinorrhoea.

Patients may relate an attack of symptoms to changes in ambient humidity and temperature. Metabolic changes seen in pregnancy, puberty, the menopause and hyperthyroidism can cause the same nasal response. Certain drugs have also been implicated, particularly antihypertensives and the contraceptive pill.

Clinical features

The main clinical features include nasal obstruction, rhinorrhoea and sneezing as in allergic rhinitis. The nasal mucosa over the inferior turbinate is congested, swollen and red, occasionally completely blocking the airway. Some patients may complain that symptoms occur on exposure to sunlight, gaseous irritants such as tobacco or with ingestion of alcohol.

Management

In all but the mildest of cases, medical treatment in the form of local and systemic decongestants should be tried. Severe cases may require submucosal diathermy, laser treatment or radical turbinectomy to clear the nasal airway (Fig. 4).

Rhinitis Medicamentosa

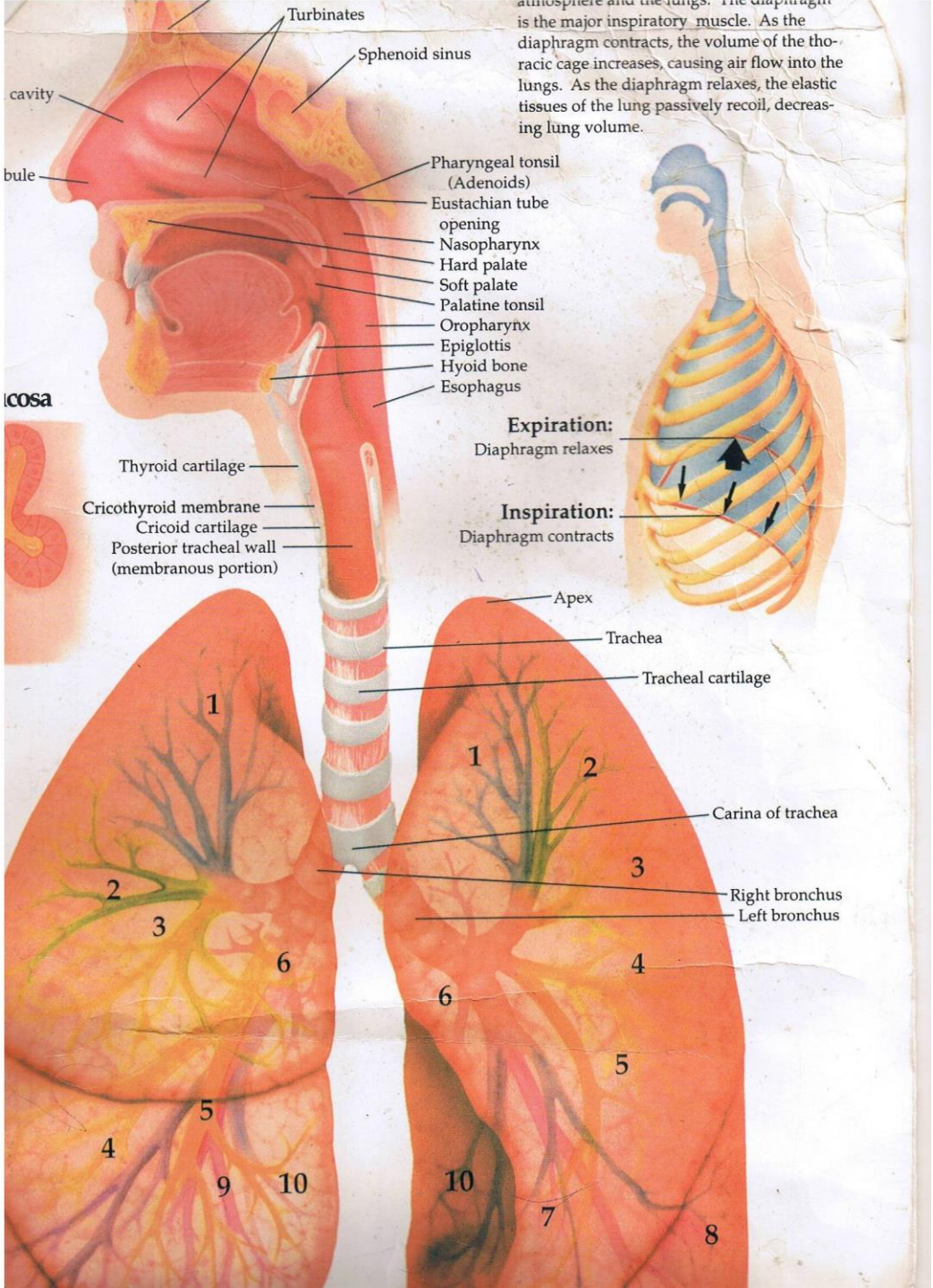
Rhinitis medicamentosa is characterized by reactive vasodilatation of the nasal mucosa. It is a result of acquired sensitivity of the nasal lining to prolonged use of topical agents, particularly those containing sympathomimetic agents. Many 'over the counter' medicines fall into this category. The patient rapidly becomes addicted to the short periods of relief produced from the severe chronic nasal obstruction.

Management

Treatment should be prophylactic, i.e. certain preparations should only be employed as 'short sharp' therapies. Established rhinitis medicamentosa requires substitution of the offending drug by one containing a steroid, or by employing a systemic decongestant. In severe cases, the mucosal swelling becomes irreversible. Such cases require surgical treatment, usually turbinate resection (Fig. 4).

Allergic and vasomotor rhinitis

- The commonest perennial allergens are household dust and dust mite.
- Pollen is the commonest seasonal allergen.
- False-negative results on skin tests are not infrequent.
- Sinofacial congestion is common in allergic rhinitis.
- Rhinitis and asthma frequently coexist as part of the same disease process.
- The mainstay of treatment of allergic and vasomotor rhinitis is medical.
- Topical nasal steroid preparations are valuable in reducing or abolishing the allergic reactions in many patients and can be prescribed long term.
- Prolonged application of potent topical vasoconstrictors leads to rhinitis medicamentosa.



is the major inspiratory muscle. As the diaphragm contracts, the volume of the thoracic cage increases, causing air flow into the lungs. As the diaphragm relaxes, the elastic tissues of the lung passively recoil, decreasing lung volume.

CHAPTER 7

Asthma

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Northwick Park Hospital and Imperial College London, UK

OVERVIEW

- Asthma should be suspected in any child who wheezes, ideally heard by a health professional on auscultation. The diagnosis is made clinically with confirmation by peak flow measurements where there is uncertainty in the older child.
- The symptoms of asthma are caused by narrowing of the bronchi and bronchioles by mucosal swelling and contraction of the muscle in their walls, with viscid secretion obstructing the lumen (Figure 7.1). The muscle contraction is reversible by a bronchodilatator such as salbutamol which is a β_2-agonist. Corticosteroids reduce mucosal oedema and secretions.
- In most children with asthma there are no symptoms or abnormal signs between acute attacks, and lung function tests, unless performed before and after exercise, are normal.
- Asthma is the most common chronic disease of childhood and it affects about 10% of schoolchildren. About 80% of children with asthma have the first symptoms before the age of 5 years and at least half will stop having attacks when they become adults.
- Prophylactic drugs and better methods of administering them have resulted in many children with asthma being completely free of symptoms.
- Treatment needs to be reviewed regularly to ensure that the child is receiving the minimum doses of drugs that produces optimal control.

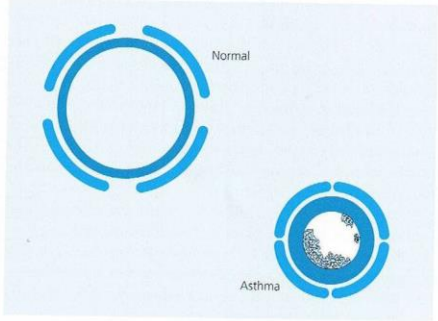

Figure 7.1 Structural changes in asthma.

Diagnosis

Asthma should be suspected if there is recurrent cough, wheezing, and shortness of breath, especially after exercise or during the night. Improvement with a bronchodilatator is helpful evidence but is not specific for asthma. The first attack may occur at any age, but to avoid many children with an acute lower respiratory tract infection being labelled as having asthma it is preferable to wait until three episodes have occurred within a year before confirming the diagnosis. There is no clinical or laboratory method of distinguishing between acute bronchial infection and asthma. Wheezes may be heard in the chest during and between attacks of asthma, but there may be no abnormal signs despite repeated examinations. The absence of night cough is the best evidence that treatment is adequate. The length of absences from school, as well as the number of hospital admissions, give an indication of the severity of the problem. Details of previous drug treatments may help to avoid the repetition of failures.

Features not commonly found in asthma may indicate an alternative diagnosis. Cough present from birth, a family history of unusual chest disease, persistent wet cough, diarrhoea, or failure to thrive suggest cystic fibrosis (see p. 41). Excessive vomiting suggests the possibility of gastro-oesophageal reflux with or without aspiration. Sudden onset suggests inhalation of a foreign body.

Most children with recurrent cough but no wheeze do not have asthma. As wheeze may not be recognized, a 2-week course of asthma treatment may be given but should be stopped if there is no improvement and the dose should not be increased. The cough is induced by a viral infection or an irritant, such as smoke, affecting airways with increased cough receptor sensitivity. The increased sensitivity is temporary and no medication reduces it.

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CHAPTER 9

Recurrent Abdominal Pain

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OVERVIEW

- Recurrent abdominal pain, which is also called the periodic syndrome, is diagnosed on the basis of at least three episodes of pain in over 3 months.
- At least 10% of schoolchildren have recurrent abdominal pain. The symptoms usually begin at the age of 5 years, although they may appear as early as 2 years or as late as 13 years. In a study of 100 children investigated in hospital only eight were found to have organic causes for the pain, including three with renal problems (Figure 9.1).
- In contrast, 60% of adults with recurrent abdominal pain have a demonstrable physical cause: most have a peptic ulcer, which is uncommon in children, or disease of the biliary tract, which is extremely rare in childhood.
- In children with recurrent abdominal pain the most common emotional state is anxiety and the most common trigger for attacks of pain is events at school.

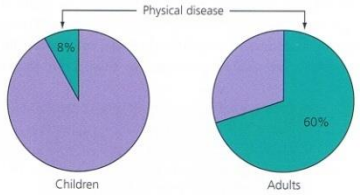

Figure 9.1 Prevalence of physical disease in children and adults with recurrent abdominal pain.

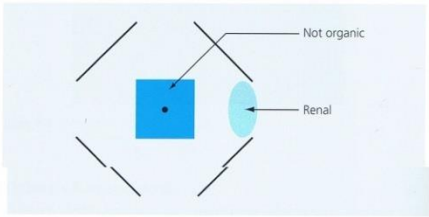

Figure 9.2 Site of pain is an indicator of cause.

History

Details of the first attack may be remembered with special clarity and may help to elucidate the cause. Two-thirds of the children have central abdominal pain, which is usually not organic in origin, but pain in other sites may have a physical cause (Figure 9.2). Pain on one side of the abdomen suggests renal disease. Aggravating and relieving factors should be considered but the type of pain is usually not helpful, and very severe pain causing the child to cry out may still derive from emotional causes. The duration and frequency of the pain, relation to meals, and whether it occurs on a particular day of the week, at weekends, or holidays are all important. Pain that wakes the child at night is likely to have an organic origin.

About two-thirds of the children have vomiting with the pain and 10% have diarrhoea during attacks. Twenty five per cent have headaches and 10% have pain in their limbs between attacks. Pallor during an attack is noticed in half of cases, and one-quarter of children are sleepy after an attack.

If there is a family history of inflammatory bowel disease or peptic ulcer there is an increased risk of these diseases in the child.

Emotional and social factors

In the parents and siblings of children with recurrent abdominal pain the incidence of similar complaints is nearly six times higher than in those of controls. The family member most often affected is the mother. There may be a history of domestic difficulties or parental illness, including depression. Parents should be asked what sort of child their son or daughter is and what disorder they particularly fear in their child. Their reactions to the child should be observed during the visit. The child's attitude to the rest of the family and to friends may need to be explored. The parents must be encouraged to say what they feel, and apparently irrelevant details about everyday life at home and at school may be of diagnostic importance.

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CHAPTER 22

Recurrent Headache

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OVERVIEW

- Any acute illness with fever may cause headache, but if there is drowsiness, vomiting, photophobia, or neck stiffness an emergency lumbar puncture needs to be considered to exclude meningitis.
- Recurrent headaches are caused by migraine, emotional tension, or intracranial pathology. Emotional factors may precipitate attacks of migraine.
- Detailed physical examination is essential on the first visit, and reassessment is needed during the first 6 months after the onset of headaches to exclude a cerebral tumour that did not produce localizing symptoms or signs initially.
- The blood pressure should be measured and the fundi examined in every child with headache.

Figure 22.1 Take the history from the child.

Migraine

Migraine occurs in about 4% of children, and tension headaches probably have about the same prevalence.The pain of migraine is usually accompanied by nausea or vomiting and is relieved by sleep. There is often intolerance to light or noise and there may be pallor. The pain lasts for hours and there is complete freedom from pain between attacks. In about 20% of patients there is a hemicranial distribution of the pain, and in about another 20% there is vertigo or lightheadedness. Only about 5% of children with migraine have a visual aura. Migraine can occur at any age, but its apparent rarity under the age of 5 years may be because of children's difficulty in discussing their symptoms (Figure 22.1).

As 90% of children with migraine have parents or siblings with this condition, the absence of a family history throws some doubt on the diagnosis. However, 50% of all children have a family history of migraine, so the presence of this history is not helpful in diagnosis. Although they may have been called migraine, the details of the relatives' headaches may show that they have the features of emotional tension headaches.

Psychological stress is the most common trigger factor of attacks, and school is often implicated (Figure 22.2). The child may have

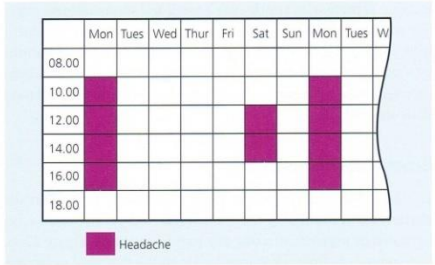

Figure 22.2 A diary may show the trigger factor.

difficulty in keeping up with his peers or may fear impending examinations. Children are often seen by a doctor for the first time at the beginning of the new school year in September, but in other families the mother may cope until March or April. Some of these children are progressing well at school but pursue a very hectic life afterwards. The importance of specific foods is controversial but a mother may have observed that a particular food such as chocolate or cheese may consistently precipitate symptoms. This occurs in about 10% of children. Provided that only one type of food is

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Table 16.2 Childhood psychiatric disorders.

Emotional disorders (neuroses)
Anxiety disorders
Somatoform disorder
Behavioural disorders
Conduct disorder
Attention deficit hyperactivity disorder (ADHD)
Depressive disorder
Developmental disorders
Pervasive (e.g. autism)
Specific (e.g. specific reading disorder)
Miscellaneous conditions
Enuresis
Encopresis
Selective mutism
Tics

- Commonest diagnoses are emotional disorders and conduct disorders.
- Disorders are commoner in children with learning disability, epilepsy and chronic physical

Factor	Examples
Genetic	Autism
Environmental	
Family factors	
Parenting styles	Harsh, critical style associated with conduct disorder
Parental conflict	Increased risk of emotional or conduct disorder
Parental psychiatric disorder	Increased risk of eating disorder
Social factors	
Deprivation	Increased risk of conduct disorder
Bullying	School refusal
Other factors	
Prematurity	Increased risk of developmental delays and behavioural disorders
Medical disorder	Epilepsy increases risk of most disorders
Physical abuse	Increased risk of emotional and behavioural disorders

Somatoform disorder

Children readily develop somatic symptoms, especially when stressed. Non-specific abdominal pain and headaches are the commonest and may lead to a paediatric referral. As in adults, *somatoform disorder* describes bodily symptoms that are unexplained by a medical condition. The assessment of these requires:

- Exclusion of a medical disorder that fully explains the symptoms.
- Exclusion of emotional or depressive disorder.
- Identification of likely precipitating and perpetuating factors. For example, the child may be unhappy at home, is worried about a sick sibling or is using the symptoms to gain attention.

Management is aimed at avoiding reinforcing the symptoms (for example by teaching the parents how not to do this inadvertently) and at tackling the underlying stresses. The prognosis is variable. Some children proceed to somatoform disorder as adults.

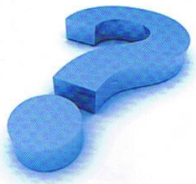
Other emotional disorders

Obsessive–compulsive disorder in children is rare clinically, but has a prevalence of 1 in 400 in British 5–15 year olds. It is sometimes associated with Tourette syndrome (see below). It is the only childhood emotional disorder with good evidence that

MEDICAL ARTICLE

Dr. Sylvia Doo
Specialist in Paediatrics
Child Development and Assessment Centre
St Paul's Hospital

What's new about Attention Deficit Hyperactivity Disorder



Attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed neurobehavioral disorder that typically begins in childhood and often persists into adulthood. ADHD is characterized by developmentally inappropriate levels of inattention and hyperactivity resulting in functional impairment in academic, family, and social settings. There are increasing trends in prevalence during the past decade and increases in ADHD medication use. The worldwide-pooled (for all age) prevalence was 5.29% [1]. The American Psychiatric Association stated that 3%-7% of school-aged children have ADHD [2]. The prevalence of ADHD in Hong Kong is 6.1% in Primary 1 schoolboys and 3.9% in early adolescence [3, 4]. In this article, I would like to highlight some latest update on this topic.

AAP Clinical Practice Guideline on ADHD 2011

The American Academy of Pediatrics had published the latest clinical practice guideline in 2011 [5]. Attention should be paid to the few key action statements:

1. With emerging evidence, evaluation for ADHD can be initiated for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.

2. To make a diagnosis of ADHD, the DSM-IV criteria should be met, including documentation of impairment in more than 1 major setting. Information should be obtained primarily from reports from parents or guardians, teachers, and other personnel involved in the child's care. Any alternative cause should also rule out.

3. Assessment for other conditions that might coexist with ADHD should be included. These include emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g., learning and language disorders or other neurodevelopmental disorders), and physical (e.g., tics, sleep apnea) problems.

4. ADHD should be recognized as a chronic condition and, therefore, consider children and adolescents with ADHD with special health care needs.

5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:

a. For preschool-aged children (4-5 years of age), evidence-based parent- and/or teacher-administered behavior therapy is the first line of treatment. Approved medication may be added if there is no significant improvement with moderate-to severe continuing disturbance in the child's function. This special recommendation based on study finding that that many young children experience improvements in symptoms with behavior therapy alone, and the overall evidence is strong. Depending on severity, many young ADHD children might still require medication to achieve maximum improvement, and medication is NOT contraindicated for this age.

b. For elementary school-aged children to adolescents (6-18 years of age), approved medications for ADHD is the first line treatment with/without evidence-based behavior therapy, preferably both. Evidence is particularly strong for stimulant medications; and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine.

6. Doses of medication for ADHD should be titrated to achieve maximum benefit with minimum adverse effects. Because stimulants might produce positive but suboptimal effects at a lower dose, titration strictly on a milligram-per-kilogram basis is not recommended. Education of parents is an important component to ensure their cooperation in appropriate titration.

Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-V) 2013

As mentioned above, we are now using the DSM-IV diagnostic criteria for diagnosing ADHD. A new revision of DSM-V will be issued in May 2013 (Table 1) [6]. The major changes are:
1. Increase the limit for age of onset from 7 to 12 years. A substantial literature overwhelmingly indicated that the age of onset by age 7 was invalid by all criteria: not able to be reliably assessed, no clinical differences between children identified as onset by 7 versus later in terms of course,

Table 16.10 Features of attention deficit hyperactivity disorder (ADHD).

Core features
Hyperactivity
Poor attention and concentration
Impulsivity
Present for at least 6 months
Evidence for impaired functioning in two or more settings
Onset by age 9, usually by 5
Other features
Distractibility
Poor at planning and organizing tasks
Learning difficulties
Clumsiness
Low self-esteem
Socially disinhibited
Unpopular with other children
Non-localizing neurological signs
Conduct disorder coexists in 50%

Autism

Autism is a syndrome characterized by a failure to develop normal communication, especially social and emotional communication. Autistic children have a delayed, restricted and deviant use of language. They seem oblivious to non-verbal cues and emotional expressions, with little desire to interact with others or form relationships. Instead, they demonstrate a limited range of solitary, repetitive behaviours and resist attempts to change their routine. Most also have a degree of learning disability. The features are summarized in Table 16.11.

- A very few autistic children (and adults), called *idiot savants*, have remarkable abilities in discrete areas, such as complex mental arithmetic (as in the film *Rain Man*).

The differential diagnosis of 'true' autism com-

Table 16.11 Features of autism.

1 in 2000 children
80% are boys
Age of onset <3 years
Key features (the 'autistic triad')
No emotional warmth (autistic aloneness)
Impaired language and communication
Solitary, repetitive behaviours
Associated features
Mannerisms and rituals
Epilepsy in a quarter
Learning disability in 75%
Non-specific behavioural problems

Tics

Tics are involuntary, rapid, spasmodic movements, usually repeated blinking and grimacing. They are common, especially in young boys, and may begin after an emotional upset. They are generally transient and need no specific treatment. However, some tics become severe, prolonged and incapacitating.

The main tic disorder is (*Gilles de la*) *Tourette syndrome,* in which tics are accompanied by

Intelligence

OUR UNDERSTANDING OF INTELLIGENCE is somewhat limited. We know that it has something to do with mental functioning. It is presumed that the more intelligent a child, the more successful this child will be in school and in job performance later on in life. This may be generally true, but not necessarily so. Other factors such as diligence, motivation, interest, encouragement and opportunity also play a big part.

INTELLIGENCE QUOTIENT

Sometimes, we speak of intelligence and intelligence quotient (IQ) in the same breath as if they mean the same thing. They do not. IQ is a mathematical abstraction derived by dividing the child's mental age by his chronological age and multiplying this by 100.

Through a test, a child's mental age can be obtained. His score will be compared to the average score of children of the same age. Thus if a nine-year-old child performs like most other nine-year olds, his mental age and chronological age would both be nine and his IQ would be 100. We can say that a child with an IQ of 100 is of average intelligence compared to his peers.

However, if both a six-year old and a 10-year old have a similar IQ of say, 110, they are not equally intelligent. The older child will most certainly outperform the younger in many intellectual tasks.

INTELLIGENCE TESTS

An intelligence test can measure a child's performance in a range of tasks such as arranging a series of pictures to tell a story, matching designs, giving meanings of words and orally repeating an increasing sequence of numbers.

However sophisticated, an intelligence test merely samples a narrow range of a child's abilities. Since the results depend on the child's performance, it is important to have test conditions kept to an optimum. The type of test used is also important. Tests developed in one country may be unsuitable for use in another. Needless to say, IQ tests should be conducted by qualified persons who are trained to administer them and to interpret the results.

Because of the inherent uncertainties of the testing conditions and other problems, ideally results should not be given as a single score but as a range, e.g. 105 to 115.

given social situation, you are probably more interpersonally intelligent than others who feel uncomfortable interacting with people.

There is a great deal of overlap in these types of intelligence. They are areas of ability that are not easily measured, but can be of great importance in determining a person's career path. Observe your child's interests and provide opportunities for him to pursue them.

There are two other ways of looking at intelligence. One distinguishes between fluid intelligence and crystallised intelligence. Fluid intelligence is reflected in general reasoning ability, attention span, memory and problem solving. It is what an individual is born with. Crystallised intelligence is acquired through learning and experience, of which a person's vocabulary and general knowledge are examples.

The second approach to intelligence considers the human brain as a very sophisticated computer which organises, stores and retrieves information. The more intelligent a person is, the more efficient these processes are.

INTELLIGENCE AND CREATIVITY

There is a difference between intelligence and creativity. What we normally refer to as intelligence and what is normally assessed in intelligence tests is convergent thinking – reasoning from the general to the specific.

Creativity is characterised by divergent thinking, that is, thinking that derives many plausible solutions from a given problem.

If you ask a creative child what he can do with a cup, he is not likely to just say that you could drink from it. This child may say that you could display it, you could also hammer it on the table to gain attention, put flowers in it, break it and scratch somebody with it, cup a spider with it, stretch a balloon over its mouth to make a drum or step on it to gain extra height.

Notice that this child does not merely have many ideas, but each one of them is distinct from another. Moreover, some of these ideas are rather unusual. In creativity, we look for the number of ideas and the degree of originality.

Many people argue that in today's complex world, it is not enough to be a convergent thinker. We need to think divergently. It is interesting to note that when children are encouraged to think divergently, their scores of creativity increase. This suggests that children can be encouraged to be more creative, given the right environment.

Unfortunately, because creative children may be more independent and non-conforming, they may be seen as more troublesome. Whether at home or in school, our insistence on the "correct" way to do things may unwittingly discourage creativity. Playfulness, humour and fantasy seem to be common characteristics of creative individuals. Parents and teachers should not be too quick to discourage such qualities.

and praising your child when she shows acts of kindness.

You can also teach children of this age group to be considerate by giving them the opportunity to play games which require cooperation and turn-taking with their peers.

PERSPECTIVE-TAKING SKILLS

Understanding another person's feelings and intentions is called perspective-taking. Children go through different stages in acquiring this ability. Once it is securely gained, children interact more successfully with one another. Accurate perspective-taking causes them to display empathy, generosity, sharing, cooperation and helpfulness.

Even though perspective-taking seems to take place in the natural course of events, this ability differs from one person to another. Some children even misread cues and therefore respond inappropriately. Evidence suggests that this is the case with some aggressive children. Compared to others, they are more likely to misinterpret other people's intentions as aggressive and thus behave aggressively in response.

Perspective-taking skills can be trained. This is done most successfully if caregivers and other adults around the child encourage her to think how another person would feel in response to one situation or another. For example, when the child snatches a toy away from another, the adult could say, "How do you think *he* feels when you snatch away his toy. If he were to snatch yours away, how would *you* feel?" Another powerful way for children to learn appropriate responding is through imitation. If adults around a child show good social behaviours such as kindness, consideration and cooperation, the child's interaction with other people is likely to be similar.

INTERACTION SKILLS

Children who successfully join ongoing activities have a knack of first hovering near the group, then engaging in parallel activities. After a while, the group will usually invite this child to join in.

On the other hand, a less skilful child may end up pleading, nagging or making a nuisance of herself. On being rejected by the other children, the child may "take revenge" by interrupting ongoing play. Sometimes she may even become aggressive. She may call for adult intervention. This, of course, does not endear the child to her peers.

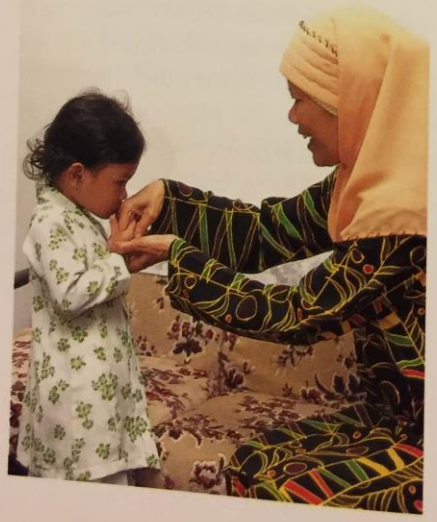
As a child grows up, she increasingly orientates herself outside her family, making friends in school and the neighbourhood. It is therefore important for the child to develop good relationship skills so that she will be more likely to relate well with others. This suggests ample opportunities to relate to peers. Playing with peers should not be deemed less important than music, ballet lessons or tuition.

During your child's play or in her interaction with others, opportunities present themselves for the alert parent to encourage the child to take

When you take your child along to visit relatives or friends or when they visit your home, encourage your child to greet them. Similarly, at departure, teach your child the appropriate greeting of your language community. When your child comes home, say, from nursery school, encourage her to greet you. When she goes out on a shopping trip for example, expect her to take proper leave of elders at home.

At mealtime, children should be encouraged to invite others to the meal before helping themselves. Mealtime is a social activity. Have your child join you at the table instead of dishing up her share in a bowl and letting her wander off to watch her favourite TV programme.

Doubtlessly, there are other rules of etiquette appropriate to your community that you can think of. The earlier you inculcate these, the easier it is for your child to incorporate them as habits.



RESPECT

Asian societies place a premium on respect, ordered relationships between individuals in different status positions. There is a reciprocity in relationship. Children are taught to respect their elders. In return, their elders exercise responsibility over them. An emphasis on individual rights outside this network of reciprocal relationships does not sit well in Asian societies.

From an early age, a child should be taught to accord respect to her elders. This includes older siblings, parents, aunts, uncles and grandparents. Later, she should learn to extend this respect to others, for example babysitters, domestic helpers, neighbours, refuse collectors and teachers.

One way of showing respect is to use appropriate terms of greeting. Teach your child the appropriate terms to address family members. Non-related adults are addressed as "uncle" or "aunt" together with their name if preferred, but not by their names alone.

In addition, a Malay child may greet her elder by lifting the older person's hand to her lips. An Indian child may place both palms togeter at chest level in a sign of obeisance.

Another way to show respect is to be attentive to what is being said. This does not suggest blind obedience. However, children ought to learn to consider the views of their elders. People are more likely to take offence at a child's dismissive attitude than at polite disagreement.

Form: 1A

Name: Lee Ka Yan, David

ST. PAUL'S CO-EDUCAT

聖保羅男

		Sep., 196 63 Dec., 196 63			Jan., 196 4 Mar., 196 4		Apr., 196 4 Jul., 196 4		Total	Final
		Marks	Position	Remarks	Marks	Position	Marks	Position	Marks	Position
English	Literature 文學	76	3	Composition	61	10	68	3	68	6
	General English 文法	85	14	rather weak.	94	1	67	24	82	13
	Composition 作文	56	14	must read	65	5	65	5	62	6
	Dictation 默書	70	20	more	64	20	74	11	69	17
	Oral English 會話				62	17	52	25		
Chinese	Translation 譯文									
	Literature 國文	92	2	能用心，肯學習，	87	9	86	8	88	5
	Composition 作文	58	5	成績自佳。	59	4	61	3	59	3
	Calligraphy 書法	50	41		85	11	60	31	65	27
Humanities	History 中史	91	3	成績優良.	79	8	83	9	84.3	6
	History 外史	74	6	Good.	75	7	78	7	75.7	7
	Civics 公民								72	10
	Scripture 聖經	59	22		90	4	82	8	77	10
	Geography 地理	72	11	Good	75	18	65	10	71	11
Mathematics	Arithmetic 算術	88	4	Quite Good.	92	6	75	7	85	6
	Algebra 代數	86	7		69	11	63	17	72.7	9
	Geometry 幾何									
	Trigonometry 三角									
Science	Physics 物理	85	9	Good.	70	20	84	5	79.7	7
	Chemistry 化學									
	Biology 生物									
	Zoology 動物									
	Botany 植物									
	Art 美術	53	37		55	33	53	37	54	38
	Handwork 手工 Domestic Science 家政	61	13		70	10	80	5	70	12
	Music 音樂	F			B				55	23
	Physical Training 體育	B			B+				78	6
Total 總分		1156			1252		1196		1367.4	
Average 平均		72.25			73.65		70.35		71.97	
Number of students in Form 全班人數		41				42		42		42
Position 按列名次		8				8		9		8

中一音樂
不合格!


寶B計劃
rob-b-hood
成龍
係爸爸
古天樂
係媽媽
陳木勝
導演
9.29同你 泡泡 BB


寶B計劃
27.10.2006

2010年12月8日TVB都市閒情首播

明報 9.12.2010 星期四 A18

新作《小明上廣州》李家仁勁過MC Jin

「小明問阿媽/買乜嘢畀親戚好友/小明上廣州/搭高鐵樂悠悠/飛馳越秀山/家陣廣州乜都有……」李家仁醫生嘅新作又帶畀大家唔少歡樂。（無綫電視畫面）

Emily喺8月寫過李家仁醫生首歌《大亞灣》，今次又講佢，唔係Emily特別偏心，而係李醫生喺網絡世界真係幾紅，充滿話題，佢噚日上《都市閒情》獻唱完新作《小明上廣州》，即刻引起網民熱話，YouTube版隔咗唔夠一粒鐘就有得睇！

「煲個冬瓜猛咁嘰」

如果閣下係李醫生嘅擁躉，應該記得佢以前有首《小明坐火車》，《小明上廣州》應該算係下集嚟，歌詞係咁嘅：「小明上廣州，探親友樂同遊，小明問阿媽『買乜嘢畀親戚好友』……廣州話的確最妙，棧鬼兼得意，煲個冬瓜猛咁嘰……」最爆嘅係歌中有一段rap，網民形容爲「MC Jin都要行埋一邊」。

主題粵港一家親

呢首歌好易入腦，Emily嘅同事聽完一次就唱唔停。睇返歌詞，其實都幾多「政治敏感」字眼，例如講到廣東話、河蟹等，不過唔使替佢擔心，因爲首歌主題都係講粵港一家親，一定唔會得罪人。

想睇《小明上廣州》就上呢度啦：
http://www.youtube.com/watch?v=V0l3t3ss0_0&feature=player_embedded#!


小明歌集
李家仁
CD
01 小明坐火車
02 小明上廣州
03 小明去東莞
04 小明遊深圳
05 小明上方舟
06 小明去拜年
07 小明生日歌
08 Siu Ming Visits London
09 Siu Ming Visits Guangzhou
10 Happy Birthday to You
Bonus Tracks
11 電車
12 新春喜洋洋
13 大亞灣
14 Super D
15 小明上廣州 (音樂)
DVD
01 小明上廣州 (漫畫版)
02 小明去拜年 (漫畫版)
03 小明上方舟 (漫畫版)
04 小明生日歌 (漫畫版)
05 小明上廣州
06 小明去東莞
07 小明去拜年
08 小明上方舟
09 Siu Ming Visits Guangzhou
10 電車
11 Happy Birthday to You
12 小明上廣州 (MMO)
13 小明去東莞 (MMO)
14 小明去拜年 (MMO)
15 小明上方舟 (MMO)
16 Siu Ming Visits Guangzhou (MMO)
17 電車 (MMO)
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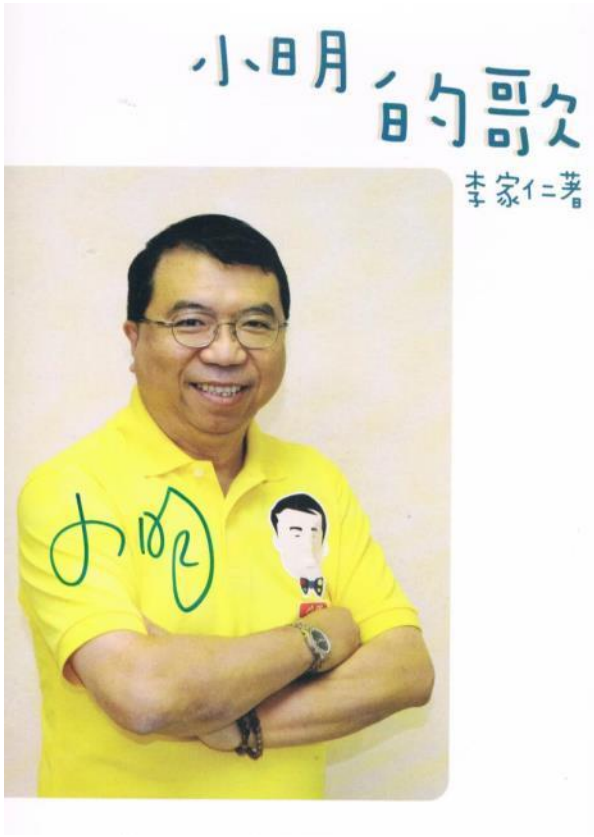
小明的歌
李家仁著


YAHOO!
BUZZ
AWARDS 2011
大獎
小日日
YAHOO!


HONG KONG

溫暖人間
BUDDHIST COMPASSION
311期
2014年7月21日
雙周四出版

小明的快樂傳播

柔道·動禪的一刻

阿姜布拉姆法師講座輯錄

敞開你的心

生活有阻滯怎化解？

轉運大法