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TREND OF LOW BIRTH WEIGHT AND ITS RELATIONSHIP WITH SOCIO-DEMOGRAPHIC FACTORS IN HONG KONG, 1984 – 1998

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Introduction

Birth weight is a good predictor of infant survival and is associated with morbidity, childhood growth and adult height.[1,2,3] The World Health Organization has also recommended the percentage of live births with birth weight less than 2.5 kg as a health indicator.[4]

The term low birth weight (LBW) is applied to all live births weighing less than 2.5 kg and very low birth weight (VLBW) to those less than 1.5 kg.[1,2,3] The two groups of babies are of particular interest because infant mortality for LBW and VLBW were 21 and 90 times respectively that for infants with normal birth weight.[2] Determinants of LBW and VLBW include genetic and constitutional factors, socio-demographic factors, obstetric factors, nutritional factors, maternal morbidity during pregnancy, antenatal care and toxic exposures like smoking, alcohol drinking and substance abuse.[1,5]

Objectives

The objectives of this article are to study the trend of LBW from 1984 to 1998 in Hong Kong and to examine the effect of socio-demographic factors on LBW using the 1998 data by the logistic regression model.

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Source of Data

Information on birth weight has been collected through the birth statistics system involving the Hospital Authority (HA), Department of Health (DH), Census and Statistics Department (C&SD), and Immigration Department (ImmD) since 1984. Basic information including the birth weight, sex, birth order and age of parents is recorded by nurses on a statutory birth return (BDR 19) after delivery. At the time of birth registration, staff of the Birth Registry of the ImmD put in further information provided by the parents, including parents' educational attainment and occupation, marital status of mother, length of stay of parents in Hong Kong and type of housing of mother. Such information is then sent to the C&SD for further data processing. The data from 1984 to 1998 provided by the C&SD were analysed.

Trends of Birth Weight, 1984-1998

From 1984 to 1998, there were 1 033 247 known live births in Hong Kong. Among them, 533 882 (51.7%) were male, 497 951 (48.2%) were female and 1 414 (0.1%) had missing information on sex. The male to female ratio was 107:100. The weights of 1 031 156 births were recorded, representing 99.8% of all known live births during the period.

Table 1 shows the summary statistics on birth weight from 1984 to 1998. From 1984 to 1998, the mean birth weight was stable ranging from 3.18 kg to 3.21 kg while the median birth weight remained constant at 3.20 kg. The standard deviation of the birth weight fluctuated between 0.45 kg and 0.48 kg. Figure 1 depicts the distribution of birth weight of babies born in 1984, 1991 and 1998. The pattern largely resembled one another. Male

Table 1 Summary Statistics on Birth Weight, 1984 - 1998

Year	Number of Newborns*		Mean Birth Weight (kg)			Median Birth Weight (kg)	Standard Deviation (kg)	Birth Weight (kg)	
			Male	Female	Total			LBW (<2.5 kg) %	VLBW (<1.5 kg) %
1984	77 154	(77 297)	3.23	3.13	3.18	3.20	0.45	4.55	0.43
1985	76 014	(76 126)	3.24	3.14	3.19	3.20	0.46	4.44	0.44
1986	71 517	(71 620)	3.24	3.14	3.19	3.20	0.46	4.42	0.46
1987	69 859	(69 958)	3.24	3.14	3.19	3.20	0.46	4.46	0.48
1988	75 348	(75 412)	3.24	3.14	3.19	3.20	0.46	4.52	0.48
1989	69 386	(69 621)	3.25	3.15	3.20	3.20	0.47	4.44	0.51
1990	67 426	(67 731)	3.25	3.16	3.21	3.20	0.47	4.43	0.52
1991	67 766	(68 281)	3.25	3.15	3.20	3.20	0.47	4.64	0.52
1992	70 682	(70 949)	3.26	3.15	3.20	3.20	0.47	4.57	0.52
1993	70 351	(70 451)	3.24	3.15	3.19	3.20	0.47	4.69	0.50
1994	71 600	(71 646)	3.25	3.14	3.19	3.20	0.47	4.67	0.59
1995	68 600	(68 637)	3.24	3.14	3.19	3.20	0.47	4.66	0.42
1996	63 270	(63 291)	3.24	3.14	3.19	3.20	0.47	4.76	0.42
1997	59 228	(59 250)	3.23	3.13	3.18	3.20	0.48	5.16	0.58
1998	52 955	(52 977)	3.24	3.13	3.19	3.20	0.48	4.99	0.56

* The figures refer to known births whose weights were recorded. The total number of known births is quoted in brackets.

LBW = Low birth weight

VLBW = Very low birth weight

infants were heavier than female infants with an overall mean weight of 3.24 kg and 3.14 kg respectively. The proportion of LBW births increased slightly from 4.55% in 1984 to 4.99% in 1998 and the proportion of VLBW births rose from 0.43% to 0.56% over the same years.

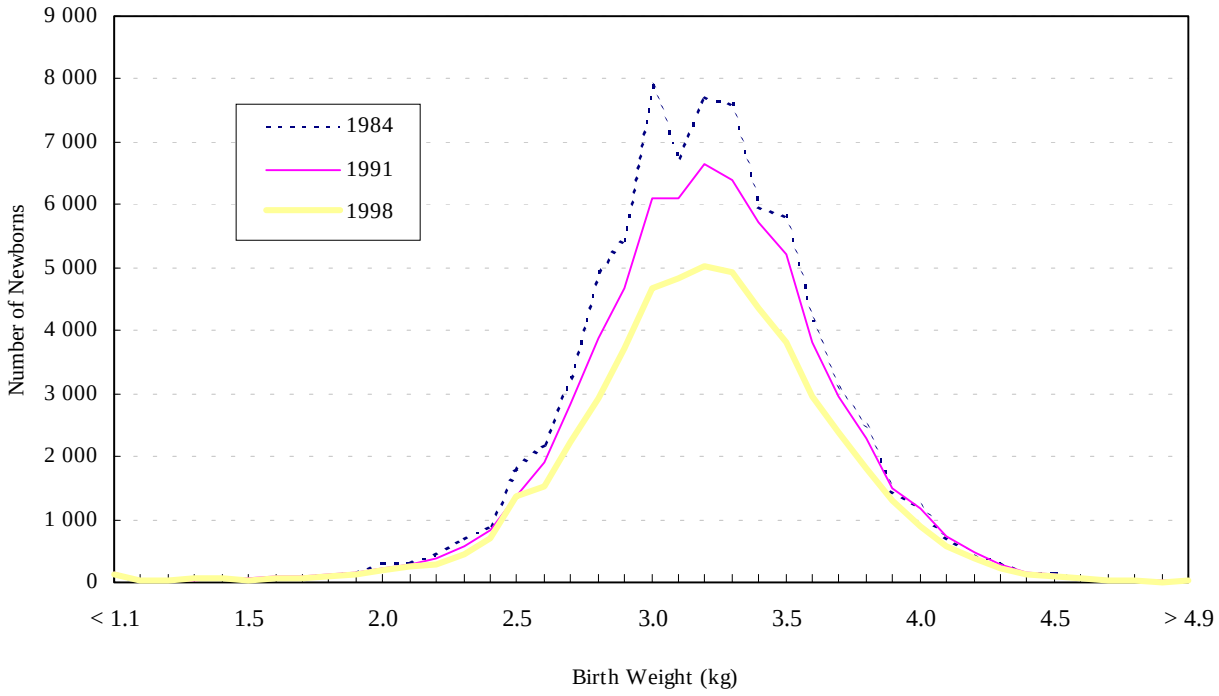
Relationship between LBW and Socio-demographic Factors

Examination of the relationship between 17 socio-demographic factors available in the BDR 19 and LBW infants in 1998 revealed that nine factors were significantly associated with LBW (Table 2). They were twins and triplets, mother's age when the child was born, place of birth of child, length of stay of father in Hong Kong, sex of baby, place of previous residence of mother, birth order, duration between dates of parents' marriage and birth of child and length of stay of mother in Hong Kong. On the other hand, factors like educational attainment and occupation of parents were not associated with LBW. It is important to note that the logistic regression model could only explain a small part of the variation in LBW.

Discussion

The mean birth weight among live births in Hong Kong has remained stable during 1984–1998. However, there has been a small increase in the percentage of LBW and VLBW babies. The reasons for this rise have not been fully elucidated. An increase in the proportion of multiple births (1.46% in 1984 vs. 1.75% in 1998) may have been partly responsible, presumably due to the more widespread use of assisted reproductive technology. With more advanced neonatal intensive care, labour can be induced at an earlier gestational age in complicated pregnancies where continuation of pregnancy poses a threat to the lives of the mother and baby. This may also have led to an increased proportion of LBW babies. There are insufficient data on the trends of other factors identified in the study to assess

Figure 1 Number of Newborns* by Birth Weight, 1984, 1991 and 1998



* Known births whose weights were recorded.

Table 2 Results of Logistic Regression for LBW Infants in 1998

Socio-demographic Factor		Odds Ratio	95% Confidence Interval for Odds Ratio	p-value*
Socio-demographic factors which were found statistically significant :				
1. Type of birth				
Triplets	(vs. single)	282.34	65.89 - 1 209.85	<0.001
Twins	(vs. single)	22.13	19.07 - 25.68	<0.001
2. Mother's age when the child was born				
≤ 16 years	(vs. > 16 years)	2.30	1.02 - 5.20	0.044
3. Place of birth of child				
Institutions of the Hospital Authority	(vs. other institutions)	1.55	1.39 - 1.71	<0.001
4. Length of stay of father in Hong Kong				
≤ 1 year	(vs. >1 year)	1.41	1.12 - 1.77	0.004
5. Sex of baby				
Female	(vs. male)	1.35	1.23 - 1.47	<0.001
6. Place of previous residence of mother				
Hong Kong	(vs. non-Hong Kong)	1.24	1.11 - 1.38	<0.001
7. Birth order				
1st order	(vs. others)	1.22	1.10 - 1.35	<0.001
8. Duration between dates of parents' marriage and birth of child				
≤ 1 year	(vs. > 1 year)	1.21	1.08 - 1.35	0.001
9. Length of stay of mother in Hong Kong				
≤ 1 year	(vs. > 1 year)	0.72	0.63 - 0.84	<0.001
Socio-demographic factors which were found not statistically significant :				
1. Place of previous residence of father (Hong Kong, non-Hong Kong)				
2. Marital status of mother (first-married, re-married)				
3. Occupation of mother (professionals, non-professionals)				
4. Educational attainment of mother (primary and below, secondary and above)				
5. Occupation of father (professionals, non-professionals)				
6. Educational attainment of father (primary and below, secondary and above)				
7. Type of housing of mother (permanent, temporary)				
8. Father's age when the child was born (≤ 16 years, > 16 years)				

Notes : 1. * p-value indicates the statistical significance of the regression coefficients.

2. $R^2 = 0.107$

whether they could account for the increase in the proportion of LBW infants over the years. Moreover, these factors may not be intrinsically associated with LBW but are only markers for some other underlying factors. For example, some hospitals that are referral centres may have more pregnancies with LBW under their care.

The association between LBW and some of the socio-demographic factors, such as multiple birth, young maternal age, female gender and first birth is well documented.[1,6] Although young maternal age is a risk factor for LBW in this study, the proportion of teenage pregnancies in Hong Kong has remained fairly stable during the study period and thus may not account for the increase in the proportion of LBW babies. It is interesting to note that mothers who were Hong Kong residents had increased risk of having LBW babies compared with babies born to non-Hong Kong residents. Whether this reflects genetic or environmental differences is not clear.

It is remarkable that the review did not find any association between LBW and markers for socio-economic status (i.e. educational attainment and occupation of parents). This was contrary to observations reported in studies in western countries.[1,7] One possible reason for the difference concerns with the provision and utilization of antenatal care. Unlike countries where access to and utilization of antenatal care are determined by insurance plan and socio-economic status[8,9,10], Hong Kong offers universal access to antenatal care. Antenatal care is delivered free of charge to all pregnant women at 50 maternal and child health centres of the DH and obstetric clinics of the HA. It is also readily available at an affordable price from the private sector. Thus, the effects of low socio-economic status could have been greatly reduced.

Another interesting phenomenon is that, while the percentage of LBW and VLBW babies has increased, it is not coupled with a rise in neonatal mortality. On the contrary, the neonatal mortality rate dropped from 6.5 per 1 000 live births in 1984 to 1.5 in 1998. The decrease was mainly attributable to a reduction in early neonatal mortality. Advances in the management of premature births and LBW infants, leading to improved survival of these babies, probably explain the picture.

This review lacks information on many important and modifiable risk factors for LBW. These include maternal smoking, alcohol consumption, nutritional factors and others. Moreover, data on gestational age are not available, which makes it impossible to study the effects of prematurity and intrauterine growth retardation separately. Also, some of the data were based on self-reported socio-economic information that was not validated. The above factors limit the usefulness of the review.

Conclusion

The increasing trend of LBW and its underlying factors need to be studied in more details. Identification of modifiable risk factors of LBW will provide valuable information to guide preventive programmes. It is also crucial to sustain a high coverage of antenatal care in Hong Kong.

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A CLUSTER OF CLENBUTEROL POISONING ASSOCIATED WITH PORK AND PIG OFFAL IN HONG KONG

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Introduction

On 6 October 2000, the Department of Health (DH) was notified by a public hospital about a report of suspected clenbuterol intoxication after the consumption of pig offal. During 6-12 October 2000, a total of 35 reports of clenbuterol poisoning associated with the consumption of pork and pig offal were received. The DH and the Food and Environmental Hygiene Department (FEHD) conducted joint investigations on this cluster.

Case Definition

In this investigation, a case was defined as a patient who developed tremor, palpitation or other symptoms attributable to beta-agonist within eight hours after eating pork or pig offal during 5-10 October 2000. A case was laboratory confirmed if the patient's urine sample showed the presence of clenbuterol.

Epidemiological Investigation

In the 35 reports of clenbuterol poisoning, 105 persons had history of eating pork and pig offal and 82 met the case definition. The attack rate was 78%. Twenty-seven (31%) of the patients were male. The age of the patients ranged from one year to 85 years with a median of 30 years. The commonest reported symptoms were tremor and palpitation (Table 1). Some patients experienced headache, weakness and dizziness. Gastrointestinal symptoms such as vomiting and abdominal pain were relatively less common. The incubation period ranged from 15 minutes to eight hours with a median of 1.1 hours. Ninety-five percent of the patients developed symptoms within four hours after ingestion of pork and pig offal (Figure 1).

A total of 18 patients required hospitalization for 1-3 days. All of them recovered without complications. Two patients were pregnant women at a gestation

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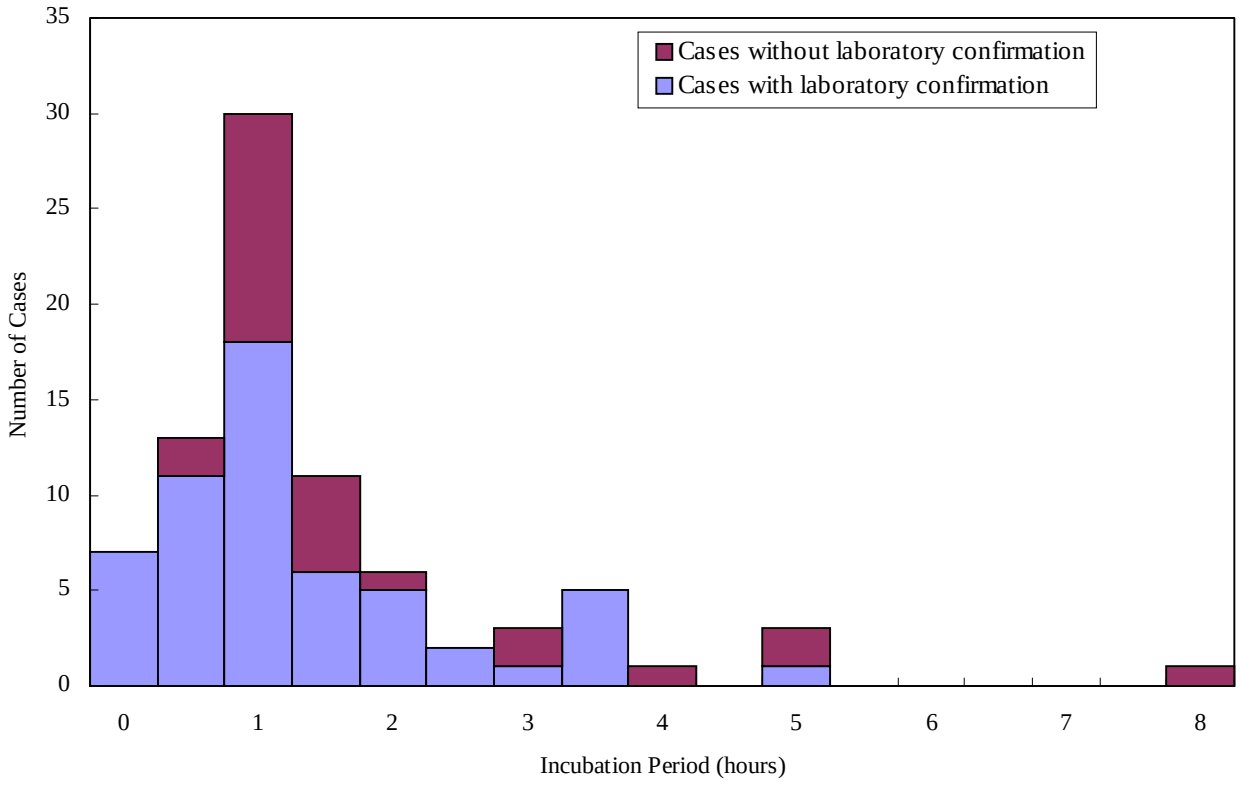
Table 1 Percentage of Reported Symptoms among 82 Cases of Clenbuterol Poisoning Associated with Pork and Pig Offal

Symptom	No. of Cases	Percentage of Total Number of Cases
Tremor	73	89
Palpitation	68	83
Headache	26	32
Nausea	17	21
Weakness	16	20
Dizziness	13	16
Vomiting	9	11
Abdominal pain	6	7
Dry mouth	6	7
Flushing	5	6
Myalgia	4	5
Dyspnoea	4	5
Chest pain	3	4
Numbness	2	2
Irritation	2	2
Facial pain	1	1

Figure 1 Distribution of Incubation Period among 82 Cases of Clenbuterol Posioning Associated with Pork and Pig Offal



of 12 weeks and 14 weeks respectively. They attended the Accident and Emergency Departments and were treated and discharged.

Thirty-three (94%) of the 35 reports of clenbuterol poisoning occurred at home. In these 33 reports, patients bought pork and pig offal from market stalls in various districts. The remaining two reports involved food premises in the New Territories.

Pig liver and pork were the commonest food items consumed in this outbreak of clenbuterol poisoning, responsible for 29 (83%) of the 35 reports. In the other six reports, patients had history of eating other pig offal including stomach, gut, lung, kidney and fallopian tube.

Laboratory Investigation

Urine samples from 61 patients of 31 reports were collected and sent to the Government Laboratory for clenbuterol investigation. Fifty-six (92%) of the 61 urine samples were positive for clenbuterol. The level ranged from 0.7μg/kg to 120μg/kg.

Seventeen food remnants were collected and they were all positive for clenbuterol. These food remnants included pork (7), liver (6), rib (2), stomach (1) and fallopian tube (1). The levels of clenbuterol in internal organs were generally high. The clenbuterol concentrations in food remnants are shown in Table 2. Interestingly, the patient with the longest incubation period of eight hours had consumed pork, and the food remnant tested positive for clenbuterol with a concentration of 400μg/kg.

Follow-up action

The FEHD inspected the 15 implicated market stalls and food premises, and collected 23 samples of pork and pig offal for clenbuterol testing. Ten of these samples were tested positive for clenbuterol. The remaining pork and pig offal were surrendered to the FEHD for disposal. Positive samples were followed up with prosecution actions.

Discussion

Clenbuterol (4-amino-α-[(*tert*-butylamine)methyl]-3,5-dichlorobenzyl alcohol hydrochloride) is a beta-agonist. As an animal feed for pigs, it induces muscle hypertrophy and reduces fat deposition by stimulating protein deposition in striated muscle. Ingestion of clenbuterol-contaminated pork and pig offal may result in beta-adrenergic symptoms such as tremor and palpitations. The incubation period usually lies between 30 minutes and six hours. Clenbuterol is excreted predominantly via urine in its

Table 2 Clenbuterol Concentrations in Food Remnants

Food Remnant	Level of Clenbuterol (μg/kg)
Liver	190 - 3 060
Pork	2 - 460
Stomach	390
Rib	180 - 260
Fallopian tube	40

unmetabolized form. It has a half-life of 29-35 hours.[1,2]

With 35 reports affecting 82 persons within one week, this outbreak of clenbuterol food poisoning is the largest recorded in Hong Kong so far. Outbreaks of food poisoning caused by clenbuterol have been reported in Europe since 1990.[3] In Hong Kong, the first confirmed outbreak was reported in 1998. In 1998 and 1999, there were one and eight reports involving one and 16 persons respectively. During January through September 2000, there were five reports affecting eight persons.

At present, there is no legal control on the feeding of clenbuterol to pigs. However, there is a screening and source tracing system in place. Different batches of imported pigs and pigs from local farms have to bear distinctively assigned tattoo numbers before they are slaughtered so that their origins can be traced. In addition, pigs imported from the Mainland must come from registered farms and be accompanied by Animal Health Certificates issued by the State Administration for Entry-Exit Inspection and Quarantine of the People's Republic of China certifying that they have not been fed with clenbuterol. For the screening of beta-agonists residues, about 50 000 pig urine samples are collected at the slaughterhouses for testing every year. If such residues are found in the samples, it indicates that the entire batch of pigs with the same tattoo number may have been fed with clenbuterol. Appropriate actions will be taken to handle these pigs and their offal.

Clenbuterol is also routinely monitored by the FEHD's food surveillance programme. The positive rate for 1999 and 2000 was 1.1%. Retailers found selling pork and/or pig offal contaminated with beta-agonists are prosecuted under the Public Health and Municipal Services Ordinance. The offenders are liable to a maximum fine of $50,000 and six-month imprisonment.

The reasons why this large outbreak occurred at this time were not entirely clear. Illegal slaughtering of tainted pigs raised locally was a possible cause. It might be related to an increased demand for pork around the Chung Yeung Festival on 6 October 2000. The FEHD has launched a territory wide operation to inspect all meat stalls selling fresh pork and pig offal. The FEHD has also stepped up its surveillance for clenbuterol at slaughterhouses and retail outlets.

To further tackle the problem, new legislative measures are being drafted by the Agriculture, Fisheries and Conservation Department which include prohibiting the use of clenbuterol in animal feeds.[4] The public can assist by reporting illegal slaughtering of pigs to the FEHD. To minimize the chance of buying pig offal contaminated with clenbuterol, they should only patronize reputable retailers. Physicians should consider clenbuterol poisoning in the differential diagnosis and ask for a history of pig offal consumption when they see patients presenting with symptoms of beta-adrenergic stimulation. They should refer these patients to the Regional Offices of the DH for further investigation.

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NEWS IN BRIEF

Notification of Infectious Diseases

The Quarantine and Prevention of Disease Ordinance (Cap. 141) requires medical practitioners to report diseases of public health importance to the Director of Health, whether suspected or confirmed. At present, there are 27 diseases notifiable under the Ordinance.

The standard notification form DH1(s) is used to report cases of infectious diseases other than tuberculosis. A separate form DH1A(s) is used for the notification of tuberculosis. The notification forms can be obtained by the following means:

Tel. No.	2961 8570
Fax No.	2893 9425
E-mail Address	dhenq@dh.gcn.gov.hk
Website	http://www.info.gov.hk/dh/diseases/notify.htm

Prompt notification is essential for effective surveillance, prevention and control of infectious diseases. For infectious diseases other than tuberculosis, medical practitioners are welcome to notify by telephone or by fax to the respective Regional Office, followed by sending a completed notification form to the Director of Health. The telephone and fax numbers are listed below:

Regional Office	Fax No.	Tel. No.
Hong Kong	2572 7582	2961 8791
Kowloon	2375 8451	2199 9100 E149
New Territories East	2603 0523	2684 5142
New Territories West	2439 9622	2615 8571

During weekends, public holidays or after office hours, urgent notification can be made to the duty Medical Control Officer of the DH (Tel. No. : 7116 3300 call 9179).

For tuberculosis, notification can be made to the Tuberculosis and Chest Service using the form DH1A(s) by post or by fax (2834 6627).

With the enactment of the Electronic Transactions Ordinance in April 2000, notifications can be submitted through electronic mail. The file of the completed forms together with the digital signature can be sent to the designated e-mail address diseases@dh.gcn.gov.hk for form DH1(s) or tb-chest@dh.gcn.gov.hk for form DH1A(s).

Apart from the 27 notifiable infectious diseases, medical practitioners are urged to report to the respective Regional Office of the DH on diseases of public health concern, such as Haemophilus influenza meningitis, Japanese encephalitis, Boutonneuse fever, Hantavirus infection, Listeriosis, Creutzfeldt-Jakob disease (CJD), E coli O157:H7 infection, acute flaccid paralysis and heavy metal poisoning. Suspected outbreaks of infectious diseases in institutions (child care centres, schools, elderly homes, etc.) like gastroenteritis, influenza-like illness, scabies, and hand, foot and mouth disease should also be reported to the Regional Office.

Public Health & Epidemiology Bulletin – A Bimonthly Publication

In order to keep readers posted of the current information on public health issues, the Editorial Board of the Public Health and Epidemiology Bulletin decided to publish the Bulletin more frequently. Starting from this year (2001) onwards, the Bulletin has been changed from a quarterly to a bimonthly publication. The table on number of notifications of infectious diseases has also been modified to include the bimonthly statistics as well as the cumulative totals of the current and previous years.

Surveillance of Viral Hepatitis in Hong Kong – 1999 Update Report

Since 1992, the Scientific Working Group on Viral Hepatitis Prevention (SWGVHP) has been monitoring the hepatitis situation for supporting the development of prevention strategy. In 1996 and 1997, reports on the surveillance of viral hepatitis in Hong Kong were prepared and published for information of the wider medical community. The SWGVHP has further reviewed the situation and brought the information updated as of the end of 1999. Hard copies of the 1999 Update Report are now available from the Secretariat (Mr John Yip at 2304 6100). The Report can also be downloaded from the website http://www.info.gov.hk/hepatitis.

NUMBER OF NOTIFICATIONS OF INFECTIOUS DISEASES

DISEASE	January 2000	December 2000	January 2001
	Cases	Cases	Cases
1) Cholera	-	2	-
2) Plague	-	-	-
3) Yellow Fever	-	-	-
4) Acute Poliomyelitis	-	-	-
5) Amoebic Dysentery	-	-	-
6) Bacillary Dysentery	4	23	33
7) Chickenpox	1 232	1 217	1 493
8) Dengue Fever	-	4	-
9) Diphtheria	-	-	-
10) Food Poisoning : *Outbreak*	44	37	50
Persons Affected	147	180	156
11) Legionnaires' Disease	-	1	-
12) Leprosy	-	1	-
13) Malaria	5	1	3
14) Measles	4	5	3
15) Meningococcal Infections	1	-	-
16) Mumps	6	11	8
17) Paratyphoid Fever	1	-	4
18) Rabies : *Human*	-	-	-
Animal	-	-	-
19) Relapsing Fever	-	-	-
20) Rubella	10	6	8
21) Scarlet Fever	20	8	10
22) Tetanus	-	-	-
23) Tuberculosis	542	621	503
24) Typhoid Fever	5	2	2
25) Typhus Fever	-	-	-
26) Viral Hepatitis:	71	64	123
- *A*	*59*	*32*	*70*
- *B*	*5*	*12*	*6*
- *Non-A Non-B*	*5*	*4*	*5*
- *Unclassified*	*2*	*16*	*42*
27) Whooping Cough	1	-	-

AIDS/HIV Surveillance

Cumulative Number of Cases	as at 30.9.2000	as at 31.12.2000
AIDS	487	500
HIV	1 491	1 542