

香港醫務委員會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr KYAW Lwin (HUANG Hsin Yang) (黃琛仰醫生) (Reg. No.: M02259)

Date of hearing: 18 September 2026 (Friday)

Present at the hearing

Council Members/Assessors: Prof. FOK Tai-fai, SBS, JP
(Chairperson of the Inquiry Panel)
Dr MARCET Marcus Mitchell
Dr CHAN Ngai-yin
Mr WONG Hin-wing, Simon, MH, JP
Mr TAM Lon-foong, Aidan

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Mr Simon FUNG of Messrs. Howse
Williams

Legal Officer representing the Secretary: Mr Gordon CHAN, Outside Counsel,
as instructed by Department of Justice

The Defendant is not present.

The Charges

1. The charges against the Defendant, Dr KYAW Lwin (HUANG Hsin Yang), are:

“That on 3 July 2023, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [REDACTED] (“the Patient”), in that he improperly and/or inappropriately prescribed the Patient, then of age 91, with 6 medications, namely (i) Uncough 20mg qid; (ii) Metoplex 1 tab qid;

(iii) BPP 1 tab qid; (iv) Zyrtec 1 tab bd; (v) Pholcodine 7.5ml qid (diluted with water at 2:1 ratio); and (vi) Montelukast 10mg nocte (“the 6 Medications”), without properly and/or adequately assessing:

- (a) the possible individual or combined side effect(s) of the 6 Medications to the Patient, and/or
- (b) the overlap in the pharmacological function(s) of some of the 6 Medications and the associated harm(s) to the Patient.

In relation to the facts alleged, either singularly or cumulatively, he has been guilty of misconduct in a professional respect.”

Facts of the case

2. The name of the Defendant has been included in the General Register from 15 January 1974 to the present. His name has never been included in the Specialist Register.
3. On 3 July 2023, the Patient (then of age 91) consulted the Defendant. The Patient’s symptoms included a few days of dry cough without sputum, an itchy throat (but without pain), running and blocked nose. She was afebrile. The Defendant’s diagnosis was upper respiratory tract infection, and he prescribed the following six medications: (i) Uncough 20mg qid; (ii) Metoplex 1 tab qid; (iii) BPP 1 tab qid; (iv) Zyrtec 1 tab bd; (v) Pholcodine 7.5ml qid (diluted with water at 2:1 ratio); and (vi) Montelukast 10mg nocte (“the 6 Medications”).
4. According to the Patient’s daughter, the Patient “*kept sleeping most of the day*” after taking the medications, and presented with symptoms including disorientation, memory loss and communication difficulties. On 5 July 2023, the Patient stopped taking the 6 Medications.
5. On 13 July 2023, the Patient’s daughter took the Patient to see another doctor, who told them that the presumed delirium was a result of Pholcodine, BPP and Uncough.
6. According to the Patient’s daughter, the Patient’s mental status had not completely returned to normal 12 days since stopping the 6 Medications.
7. By a statutory declaration made on 29 September 2023, the Patient’s daughter lodged a complaint against the Defendant with the Medical Council (“the Council”).

Burden and Standard of Proof

8. We bear in mind that the burden of proof is always on the Secretary and the Defendant does not have to prove his innocence. We also bear in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.
9. There is no doubt that the allegations against the Defendant here are serious ones. Indeed, it is always a serious matter to accuse a registered medical practitioner of misconduct in a professional respect. Therefore, we need to look at all the evidence and to consider and determine each of the disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

10. At the beginning of the inquiry, the Legal Officer for the Secretary offers no evidence in respect of charge (b). We will therefore acquit the Defendant of charge (b).
11. The Defendant admits to the factual particulars of charge (a) against him but it remains for us to consider and determine on the evidence whether he is guilty of misconduct in a professional respect.
12. Dr KUNG Kenny (“Dr KUNG”), the Secretary’s expert, in his Expert Report said as follows:

“The medications prescribed, their related drug class, indications and possible side effects are listed below.

C.3.1 Uncough

Generic name = *chloperastine / cloperastine*

Class:

- *Central antitussive*
- *H1 receptor antagosit (sic)*
- *Papaverine-like activity (similar to codeine)*

Indication: unproductive cough caused by common cold, acute and chronic bronchitis

Side effects: dry mouth, loss of appetite, nausea, sleepiness

C.3.2 Metoplex

Contains:

- Bromhexine (mucolytic)
- Caffeine
- Carbinoxamine (histamine-H1 receptor blocking agent)
- Dextromethorphan (non-opioid antitussive)
- Papaverine (opium alkaloid antispasmodic)

Indication: used to treat symptoms caused by the common cold, flu, allergies, hay fever

Side effects:

- Bromhexine: gastrointestinal side effects, transient rise in serum aminotransferase, headache, vertigo, sweating and allergic reactions.
- Caffeine: palpitations, dizziness, anxiety
- Carbinoxamine: Clumsiness or unsteadiness, drowsiness, sleepiness, confusion
- Dextromethorphan: dizziness, lightheadedness, drowsiness, nervousness, restlessness, nausea, vomiting, stomach pain
- Papaverine: dizziness, sleepiness, weakness, drowsiness, fatigue

C.3.3 BPP

Contains

Presumably, this "BPP" contains the following components: brompheniramine (H1 antagonist), phenylephrine (alpha agonist) and phenylpropanolamine (sympathomimetic)

Indication: symptoms of upper respiratory tract infections

Side effects:

- Brompheniramine: similar to other H1 antagonists
- Phenylephrine: palpitation, headache, restlessness, tremor, respiratory distress

- *Phenylpropanolamine: headache, confusion, dizziness, restlessness, insomnia, agitation, palpitation, blurred vision*

C.3.4 Zyrtec (cetirizine)

Indication: urticaria, perennial rhinitis, seasonal allergic rhinitis

Side effects: confusion, dizziness, drowsiness, fatigue, malaise

C.3.5 Pholcodine

Indication: cough

Side effects: confusion, dizziness, drowsiness

C.3.6 Montelukast

Indication: asthma, exercise-induced bronchospasm, allergic or perennial rhinitis

Side effects: influenza, viral infection, dizziness

C.4 Acute delirium: possible etiology

As alluded to in the previous section, [REDACTED] was likely suffering from acute delirium. There is a lack of literature on the incidence of acute delirium as a complication of upper respiratory infections. What is known is that the elderly are at risk, and various factors can predispose or precipitate its occurrence, use of antihistamines, opioids, as well as many other medications.

C.5 Comments on overall management

C.5.1 Diagnosis

Given the symptoms provided, the diagnosis made by Dr KYAW was appropriate.

C.5.2 Prescription

A total of 6 medications were prescribed by Dr KYAW, some of which have overlapping pharmacological functions (uncough, metoplex, and BPP all have antihistamines), and many of which may cause dizziness and sedation on an individual basis. By deduction, the combination of all these medications, taken within a short period of time, will much more likely result in adverse events.

...

D. Conclusion

The patient [REDACTED] was seen by Dr KYAW for symptoms of an upper respiratory tract infection, and was prescribed with 6 medications, some of which have overlapping pharmacological actions, potentially increasing the likelihood of related side effects, and especially for a patient at an age of 90 years. The absence of adverse events in the past does not preclude them from occurring in subsequent encounters, given that a patient's condition might change with time.

It is not possible to differentiate whether [REDACTED] delirium is a result of her underlying respiratory tract infection or the polypharmacy regime instigated by Dr KYAW. Nevertheless, it is likely that the polypharmacy would either precipitate dizziness and confusion in an elderly patient, or worsen such pre-existing status.

From a clinical perspective, Dr KYAW should review his prescription practice in order to minimize polypharmacy and its related harms. The prescription of combination medications must be done in a particularly cautious manner, where the doctor must understanding [sic] the exact pharmacological action of each of the component, and consider whether there are possible overlap or interaction between the medications.”

13. In his Supplemental Expert Report, Dr KUNG said as follows:

“4. A patient in the tenth decade of life requires particular caution in prescribing. Advanced age is associated with reduced physiological reserve and altered drug handling, such that a regimen which may be tolerated by a younger adult may produce disproportionate toxicity in an elderly.

...

8. Finally, older adults are especially vulnerable to polypharmacy. The combination of multiple centrally acting or anticholinergic agents may produce additive or synergistic adverse effects, including excessive sedation, dizziness, confusion, delirium, falls and urinary retention. For that reason, the accepted geriatric prescribing principle is to start low and go slow, to simplify regimens where possible, and to avoid first-generation H1-antihistamines, strongly anticholinergic agents and opioid antitussives unless there is a clear and proportionate clinical justification.

3. Typical Adult Dosing and the Significance of the Regimen in Context

9. When considered in isolation, several of the prescribed drugs were given within, or close to, nominal adult dosage ranges found in standard prescribing references...

10. However, the fact that some individual doses may sit within standard adult ranges does not determine whether the overall prescription was appropriate for this patient. The proper clinical question is whether the regimen, taken as a whole, was suitable for a 91-year-old woman with an apparently uncomplicated viral upper respiratory tract infection. A prescription of six separate medications, four of them to be taken four times daily, with substantial overlap in pharmacological action and no evident simplification to reflect the patient's advanced age and vulnerability to adverse effects, would render the prescription "excessive".

11. In geriatric medicine, overall burden matters at least as much as nominal individual dose. A regimen may be excessive not because one single drug is massively overdosed, but because the cumulative exposure, duplication and dosing frequency create a high risk of predictable harm in a frail older patient. That is the concern here.

4. Adverse Effects and Overlapping Pharmacological Actions

12. The prescribed combination carried multiple foreseeable psychiatric and neurological adverse effects. Across the regimen, the recognised adverse-effect profile includes drowsiness, dizziness, sedation, confusion, impaired coordination, restlessness, agitation and, in susceptible individuals, delirium or hallucination-like phenomena. Those risks are especially important in a patient aged 91.

13. There was clear overlap in antihistaminic activity. Cloperastine has H₁-antagonist properties. Metoplex contains carbinoxamine, which is a first-generation H₁-antihistamine. BPP contains brompheniramine, another first-generation H₁-antihistamine. Zyrtec contains cetirizine, a second-generation antihistamine. The result was the co-prescription of several agents capable of causing sedation and, in the case of first-generation agents, anticholinergic adverse effects such as confusion and urinary retention.

14. There was also overlap in antitussive and centrally acting sedative burden. Cloperastine is a centrally acting antitussive. Metoplex contains dextromethorphan, another centrally acting antitussive, and papaverine, which, although not classically categorised as a primary CNS depressant, may cause sedation and sleepiness. Pholcodine is an opioid-related cough suppressant with recognised sedative potential. In practical terms, therefore, several ingredients within the regimen converged upon the same clinical risk domains: somnolence, dizziness, cognitive slowing and impaired arousal.

15. In addition, BPP contained sympathomimetic ingredients, namely phenylephrine and phenylpropanolamine. Those drugs may contribute to restlessness, palpitations, tremor, blood-pressure effects and neuropsychiatric disturbance. This form of polypharmacy will also run the risk of inducing confusion in an elderly patient. For decongestant effects, the use of topical therapy is probably the better mode of drug delivery than oral.

16. Where multiple drugs act at overlapping receptors or upon converging physiological pathways, the result is not merely a larger number of side effects on paper. The intensity of shared adverse effects may increase in a more-than-additive manner. In a very elderly patient, overlapping sedative and anticholinergic effects may reasonably be expected to increase both the likelihood and the severity of confusion, sedation, dizziness, falls and delirium.

5. Whether the Prescription Was High in Strength or Potency for This Patient

17. In my opinion, the prescription was high in effective strength or potency for a patient of this age. I do not use that phrase to suggest that every individual dose was extreme in isolation. Rather, the strength of the regimen lay in its cumulative pharmacological burden: six medications, four-times-daily dosing for most of them, class duplication, overlapping sedative and anticholinergic activity, and use in a patient whose age alone materially increased susceptibility to adverse drug reactions.

18. For a straightforward viral upper respiratory infection in a 91-year-old, a much simpler symptomatic regimen would ordinarily be expected. The prescribing strategy here was, in my view, disproportionately aggressive relative to the benign and usually self-limiting condition being treated.

...

21. Accordingly, several combinations within this regimen should generally have been avoided in a 91-year-old patient. Those include the simultaneous use of multiple antitussives, namely cloperastine, dextromethorphan and pholcodine; the simultaneous use of multiple antihistamines, namely cloperastine, carbinoxamine, brompheniramine and cetirizine; and the broader combination of these sedating and anticholinergic agents together. Even if one accepted a role for a single symptomatic antitussive or a single antihistamine, the combined regimen went well beyond what was reasonably necessary.

22. Combining multiple centrally acting antitussives (cloperastine, dextromethorphan, pholcodine) and first-generation antihistamines (brompheniramine, carbinoxamine) poses a high risk of drug-induced delirium and cognitive impairment in elderly patients, driven by cumulative anticholinergic burden and central nervous system (CNS) depression. These agents significantly increase the likelihood of oversedation and confusion, as the elderly are highly susceptible to acute cognitive decline from multiple sedative-anticholinergic compounds.

...

29. In summary, [REDACTED] underlying presentation appears to have been that of an uncomplicated viral upper respiratory tract infection. Although several of the individual prescribed doses may have resembled standard adult dosing, the overall regimen was, in my opinion, excessive and insufficiently tailored to a 91-year-old patient. It exposed her to duplicated antihistaminic therapy, duplicated antitussive therapy and an overall sedative and anticholinergic burden that made adverse neurocognitive effects foreseeable.

30. In that setting, it is my opinion that the prescribing regimen materially increased the risk of sedation, confusion, delirium, dizziness and related geriatric harms... ”

14. The opinion of Dr KUNG is unchallenged, and we accept them in full. We are satisfied that the Defendant had improperly and/or inappropriately prescribed the Patient with the 6 Medications without properly and/or adequately assessing the possible individual or combined side effect(s) of the 6 Medications to the Patient. The Defendant has by his conduct in the present case fallen below the standards expected amongst registered medical practitioners in Hong Kong and we find him guilty of misconduct in a professional respect as per charge (a).

Sentencing

15. The Defendant has a clear disciplinary record.
16. In line with our published policy, we shall give the Defendant credit in sentencing for his admission and cooperation throughout these disciplinary proceedings.
17. We bear in mind that the primary purpose of a disciplinary order is not to punish the Defendant but to protect the public from persons who are unfit to practise medicine and to maintain public confidence in the medical profession by upholding its high standards and good reputation.
18. We have considered the commendation letters as submitted and the Defendant's participation and contributions to the community.
19. In mitigation, the Defendant's solicitor told us that the Defendant has taken remedial measures. The Defendant will now pay extra caution when prescribing medications to patients, particularly to elderly patients.
20. In our view, the offence committed by the Defendant was very serious. Polypharmacy without proper and/or adequate assessment of the individual or combined side effects of the medications could be very dangerous, particularly to elderly patients.
21. Taking into consideration the nature and gravity of the disciplinary charge for which the Defendant is convicted and what we have heard and read in mitigation, we shall order that the name of the Defendant be removed from the General

Register for a period of 1 month. We further order that the said removal order be suspended for a period of 12 months subject to the condition that the Defendant shall complete within the suspension period courses relating to safe prescription of drugs to the equivalent of 10 CME points and such courses have to be pre-approved by the Chairman of the Council.

Prof. FOK Tai-fai, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong