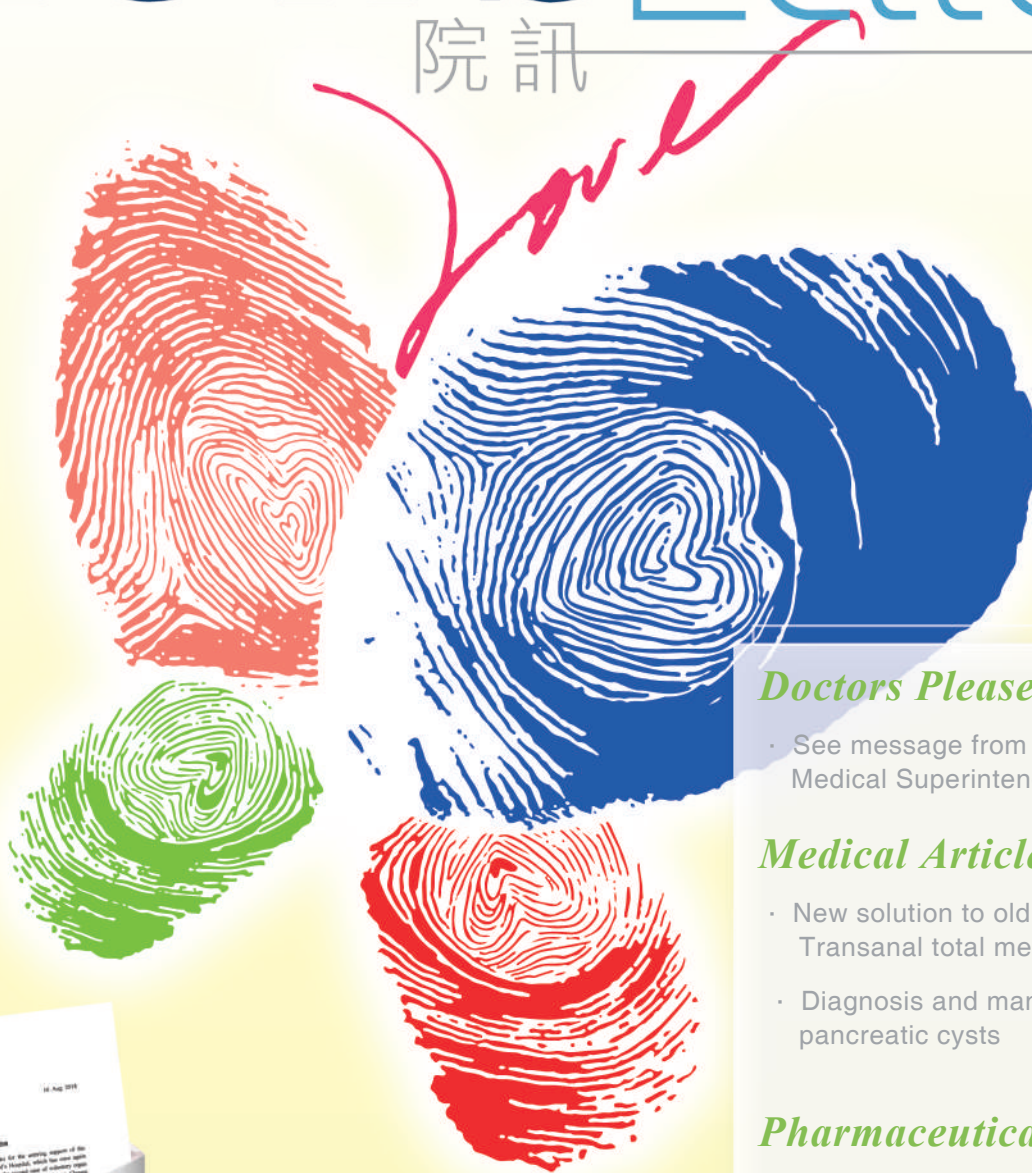




NewsLetter

院訊



Doctors Please Note:

- See message from the Medical Superintendent overleaf

Medical Article:

- New solution to old problem – Transanal total mesorectal excision
- Diagnosis and management of pancreatic cysts

Pharmaceutical Updates

- Antibiotic Stewardship Program

SPH Made History with Second Organ Donation Operation

St. Paul's Hospital became the first private hospital in Hong Kong to have supported a second organ donation operations on 7 August 2018, in addition to our first one in 2012. Great effort was spent communicating with the family in collaboration with the team from Hospital Authority. Two kidneys, a liver and two corneas were harvested benefiting multiple patients. The Hospital and concerned visiting and staff doctors not only set aside other tasks to give this lengthy procedure the highest priority, but also waived all the charges incurred. May the love of God continue to bring life and hope to the needy.



Dr. William Ho
Medical Superintendent

Doctors Please Note -

Our hospital's second Organization Wide Survey of ACHS accreditation was most successfully accomplished this year with great effort from everyone. The ACHS surveyors gave new recommendations and suggestions, quite a number of which touched on doctors, which I would like to draw your attention to:

- **Missing doctors' signatures** for counter-signing verbal orders and drug prescriptions within 24 hours: Please note that these carry legal implications and our nursing/ medical records staff are most happy to assist you through reminders.
- **Date, time, ink, legibility, abbreviations, crossing out:**
 - While it is customary for doctors to put down the date against their orders, surveyors recommended also putting down the time. This is indeed beneficial to protect doctors should there be arguments on when decisions were made, and we would encourage you to do so.
 - The use of red, green or even blue ink risks fading with time and unclear image upon photocopies – so please stick with black.
 - Legibility of handwriting is a persistent issue, and we wish to encourage you to type, or else write clearly.
 - Please don't invent abbreviations. There are also prohibited ones for prescriptions like "sc", "QD", "+", "µg", "cc" etc. which are error-prone. (Please write "subcut", "daily", "and", "mcg", "ml" instead)
 - For amending prescriptions, the best practice is to Discontinue, then prescribe again. Crossing out or amending prescriptions after drugs had been dispensed/consumed is medico-legally problematic.
- **Discharge Summary:** Doctors are expected to give a copy to patients upon discharge. There are concern from some colleagues that our current paper form of the Discharge Summary contains too many clinical details. We have changed it to two pages with the first page containing only essential information, much like the HA ones, that will be given to patients.
- **Hand Hygiene:** Surveyors distinctly drew to attention the disparity between Visiting Doctors and Staff Doctors regarding hand hygiene compliance audit results, with the latter being much closer to the hospital benchmark. Please practice HH particularly before touching patients. Also remember to practice HH even if you have not touched patients but touched the surroundings – medical record, bedside table, bedding etc. – view them as contaminated.
- **Antibiotics Stewardship:** Prescribe on an evidence-based practice and avoid using big guns where possible. Please refer to the IMPACT guidelines concerning use of prophylactic antibiotics.
- **Haemovigilance:** Both the Hong Kong Red Cross and ACHS surveyors called upon doctors to be more judicious in prescribing blood transfusion, and increase the use of iron therapy instead.

Members of the Hong Kong Private Doctors Association learned with dismay the decision of the Hospital Authority to quit the ACHS scheme. We do regard the scheme most beneficial to quality improvement and ensure patient safety. We are determined to continue so as to keep our quality standard at par with international benchmarks.

Ever since completion of our new Main Block, we are happy to see more and more Visiting Doctors admitting patients to St. Paul's Hospital. We shall continue to do our best for both our clients and our healthcare professionals to achieve the best outcome. Please feel free to give me any suggestions on ways to improve further.



New solution to old problem – **Transanal total mesorectal excision**

Colorectal cancer is the second commonest cancers in HK in 2015, with an annual incidence of 2891 cases and causes 1177 deaths per year. One of the most challenging area for the surgical treatments of colorectal cancer is the treatment for rectal cancer. Since the introduction by Prof Bill Heald, total mesorectal excision (TME) has been the gold standard treatment for rectal cancer, which has shown to decrease local recurrence and circumferential resection margin positivity rate. Although the surgical techniques and instruments have improved over the decades, TME is still a technically demanding procedure for surgeons to perform in a narrow and deep pelvis, making a challenge to maintain oncological principles as well as to protect the important anatomical features.

Since the first laparoscopic assisted colectomy performed in 1991, there was already a wealth of evidence confirming its short-term benefits as well as comparable oncological outcomes to open counterpart. However, the role of laparoscopic TME is still under intensive investigation.

Limitations for laparoscopic TME:

1. Although there have been considerable developments in laparoscopic instrumentation, surgeons still encounter lots of technical difficulties using fixed laparoscopic instruments with limited dexterity.
2. Imprecise distal margin determination
3. Laparoscopically, even with staplers that can angulate, a single firing of stapling device is rarely achievable. On the other hand, more than 2 firings is associated with a greater risk of anastomotic leak.

Development of transanal TME

The concept of transanal TME was developed in order to overcome the shortcomings of laparoscopic TME. The first transanal TME was reported by Prof Antonio Lacy in 2010 (1).

Surgical technique of transanal TME

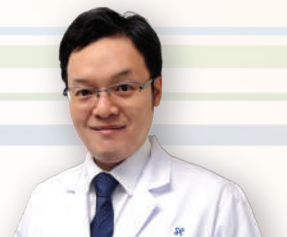
A purse-string was applied distal to the rectal tumor to tightly close the rectum. The rectal mucosa was then incised circumferentially distal to the purse-string. Distal rectal transection was then performed using transanal platform such as GelPOINT Path or TEO device. Proximal mobilization of sigmoid colon and upper rectum was performed as usual laparoscopically. The final specimen was retrieved transanally, and end-to-end anastomosis can be performed using circular stapler. So transanal TME has the advantages of avoiding double stapling and improving vision and safety for distal mesorectal excision in low rectal tumor.

Current evidence of transanal TME

There are already a number of papers reporting the safety and feasibility of transanal TME. As synchronous dissection can be performed, obviously there was reduction in total operation time. Other perioperative outcomes such as conversion rate and surgical complication rates are comparable with laparoscopic TME series, and most importantly, short term morbidity and oncological outcomes are similar as well (2,3).

References:

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Diagnosis and management of pancreatic cysts

Introduction

Due to the widespread use of cross-sectional imaging, pancreatic cysts are diagnosed more frequently in clinical practice. The prevalence in an asymptomatic population reported from 2.4 to 13.5% with increasing incidence with age (1). Some types of pancreatic cysts have malignant potential and may progress to cancer, whereas more commonly encountered small pancreatic cysts are benign and rarely have interval progression. The mainstay of treatment of pancreatic cysts is surgical resection but the surgical risk is relatively high. Large worrisome cysts are more commonly found in older individuals with medical comorbidities and limited life expectancy which is another concern.

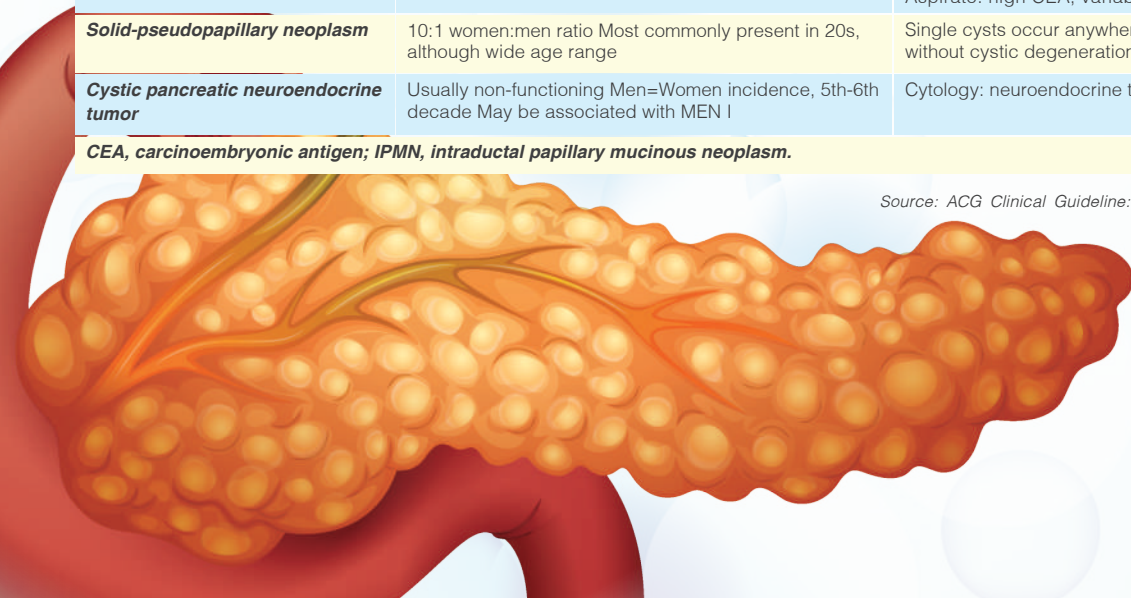
Classification of pancreatic cysts

Pancreatic cysts can be categorized as neoplastic or non-neoplastic (i.e. pseudocyst). Neoplastic cysts include Serous cystic neoplasm (SCN), Mucinous cystic neoplasm (MCN), Intraductal papillary mucinous neoplasm (IPMN), Solid pseudopapillary neoplasm (SPN). MCNs and IPMNs are mucin-producing while IPMNs, MCNs, Solid-pseudopapillary tumors and pancreatic neuroendocrine tumors are cystic pancreatic lesions with malignant potential.

Types of Pancreatic Cysts

Characteristics of pancreatic cysts		
Cyst type	Clinical associations	Imaging and fluid analysis
Non-neoplastic		
Pseudocyst	Acute and/or chronic pancreatitis	May contain fluid alone or debris Aspirate: Brown fluid, high mylase/lipase, low CEA
Neoplastic		
Serous cystadenoma	75% in women 6th decade	Microcystic / honeycomb, oligocystic less common Aspirate: low CEA, low amylase/lipase
IPMN	Men=Women 7th decade	Mucin producing, Aspirate: high CEA, high amylase
Side branch	Most common incidental cyst Low risk of cancer progression May be multifocal	Communication with main pancreatic duct Aspirate: high CEA, high amylase
Main duct	Much less common than side branch Higher risk of cancer	Dilated main pancreatic duct, may be segmental, patulous orifice in 50%
Mixed	Rare; appears to have same cancer risk as main duct	Side Branch IPMN combined with main duct IPMN
Mucinous cystic neoplasm	Almost exclusively in women 5th to 7th decade	Vast majority found in the body or tail Unilocular, may have septations or wall calcification, no main duct communication Mucin-producing Aspirate: high CEA, variable amylase
Solid-pseudopapillary neoplasm	10:1 women:men ratio Most commonly present in 20s, although wide age range	Single cysts occur anywhere in pancreas, smaller ones more solid without cystic degeneration
Cystic pancreatic neuroendocrine tumor	Usually non-functioning Men=Women incidence, 5th-6th decade May be associated with MEN 1	Cytology: neuroendocrine tumor Aspirate: low CEA, low amylase/lipase
CEA, carcinoembryonic antigen; IPMN, intraductal papillary mucinous neoplasm.		

Source: ACG Clinical Guideline: Diagnosis and Management of Pancreatic Cysts





Clinical manifestations

Many patients with pancreatic cysts are asymptomatic as the cysts are discovered incidentally. The pancreatic cysts can cause symptoms due to its large size, its location at pancreatic head causing obstructive jaundice, pancreatic insufficiency. The symptoms include abdominal pain, recurrent pancreatitis, jaundice, weight loss, new-onset diabetes mellitus.

Pancreatic cyst diagnosis

The aim is to identify lesions with malignant potential or signs of malignancy. Cysts with malignant potential include MCNs, IPMNs and SPNs. SCNs are generally benign lesions.



1) Cross sectional imaging

The diagnostic modality include cross-sectional imaging either pancreatic protocol computed Tomography (CT) or Magnetic resonance imaging (MRI) with magnetic resonance cholangiopancreatography (MRCP) for evaluation of pancreatic cysts. This helps to identify the specific cyst type and to determine any features with increased risk of malignancy. It includes cyst size >3cm, mural nodule or solid component within the cyst and dilated main pancreatic duct >5mm.

2) Endoscopic ultrasound with fine-needle aspiration

EUS-FNA provides high quality imaging of pancreas and to determine the size, location, pancreatic duct communication, presence of mural nodule on pancreatic cyst. It allows aspiration of cystic fluid and sample pancreatic lesions for histological diagnosis. Cyst fluid can be analyzed for CEA level and Cytology. EUS-FNA and cyst fluid analysis should be considered to characterize the type of pancreatic cyst when the diagnosis is unclear and the results are likely to alter management.

Cyst fluid CEA level is used to identify mucinous cyst (i.e. IPMN and MCN). The cut-off value of CEA level > 192ng/ml (2) with the sensitivity of 63% and specificity of 93%. For non-mucinous lesion, e.g. Pancreatic pseudocyst or SCN, the CEA level is less than 5ng/ml. Elevated Cyst fluid CEA does not help to identify high-grade dysplasia or pancreatic cancer.

Cyst fluid cytology should be analyzed for the presence of high grade dysplasia or pancreatic cancer. The limitation is the low cellularity of the cyst fluid sample. The sensitivity is 54-63% and specificity is 88-93% for identifying IPMNs or MCNs (3).

Cyst fluid analysis on molecular markers, such as KRAS or GNAS, are still early in development and not widely available in clinical practice.

Pancreatic cyst management

Pancreatic cyst management depends on the following factors:

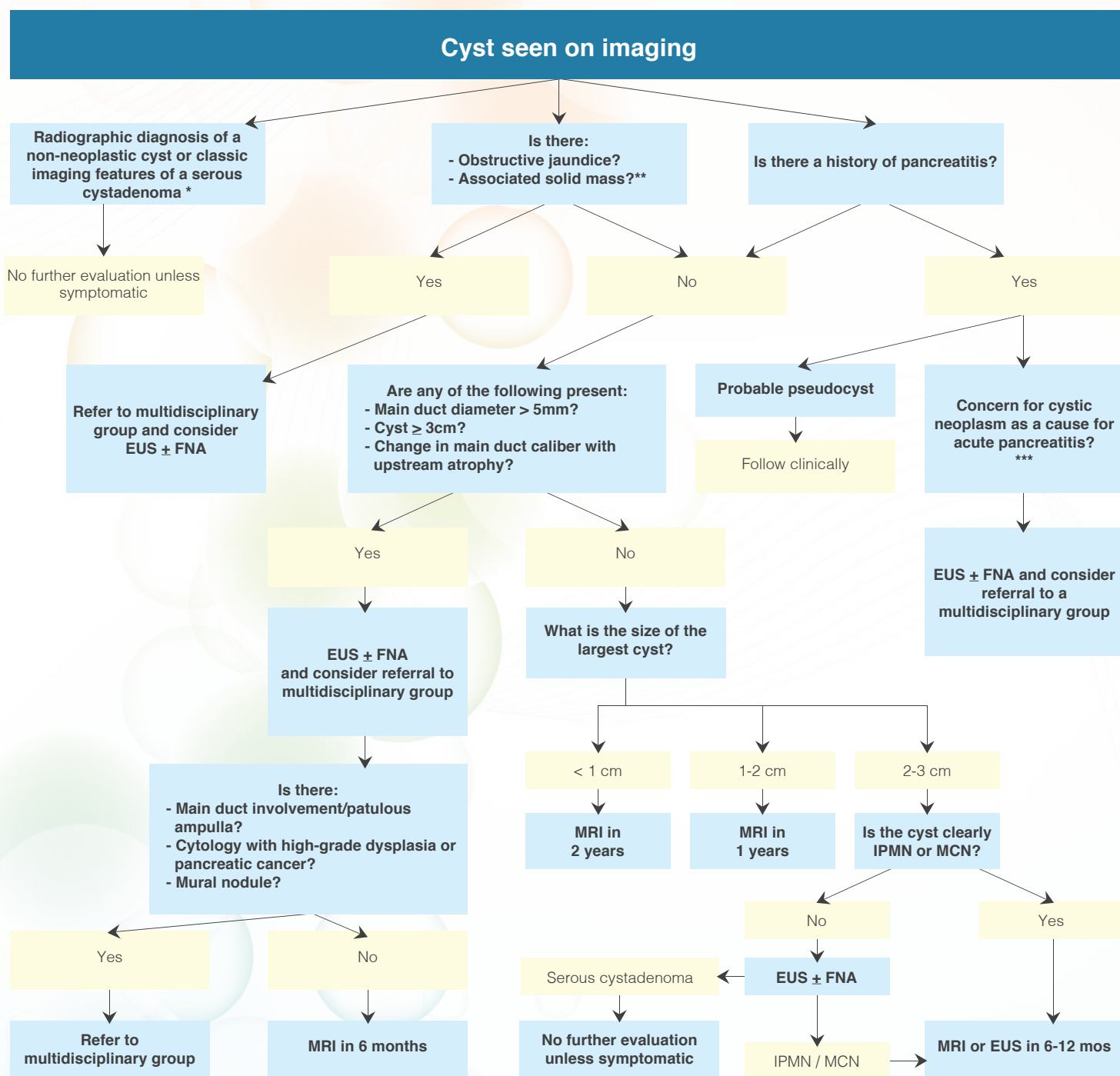
- Patients factor: Age, medical comorbidities and fitness of operation
- Clinical symptoms
- High risk radiological features: size larger than 3cm, mural nodules, dilated main pancreatic duct more than 5mm
- Risk of malignant transformation

Patients who are not medically fit for surgery should not undergo further evaluation of incidentally found pancreatic cysts. Patients with asymptomatic cysts and radiological features suggestive of Serous cystadenoma (SCN) should have no further evaluation. Patient with pancreatic cysts with typical radiological feature of SPN, Main-duct IPMN should undergo evaluation for surgery since these lesions have high risk of malignant potential. For patient with history of pancreatitis and the presence of pancreatic cyst, the diagnosis can be probably pseudocyst and it should be follow-up clinically. For patients with symptoms such as obstructive jaundice, or presence of high risk radiological features which include cyst size larger than 3cm, dilated main pancreatic duct more than 5mm, presence of mural nodules, EUS FNA with cyst fluid analysis is indicated for further evaluation and surgery may be considered. For asymptomatic, small pancreatic cysts with no high risk radiological features, serial monitor with cross-sectional imaging is indicated.

Recently published ACG Clinical Guideline on Diagnosis and Management of Pancreatic Cysts illustrated the clinical approach to patient with pancreatic cyst (4)



Pancreatic cyst management



Approach to a patient with a pancreatic cyst. *Pathognomonic radiographic features of a serous cystadenoma are a microcystic appearance with a central stellate scar. **Occasionally benign lesions can have a solid appearance. In cases where the diagnosis is unclear EUS ± FNA should be performed. *** Unusual cystic features or present at initial onset of acute pancreatitis. EUS, endoscopic ultrasound; FNA, fine needle aspiration.

Source: ACG Clinical Guideline: Diagnosis and Management of Pancreatic Cysts

Conclusion

Incidental pancreatic cysts are commonly encountered in clinical practice. Some have malignant potential but most small incidental pancreatic cysts are benign and indolent lesions that expectant management is justifiable. There is an urgent need for prospective, multicenter studies to provide evidence to guide future management.

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Antibiotic Stewardship Program in St. Paul's Hospital

SPH Pharmacy Department

What is Antibiotic Stewardship Program (ASP)?

Antibiotic stewardship program (ASP) is denoted as coordinated interventions designed to improve and measure the appropriate use of antibiotics by promoting the selection of the optimal antibiotics drug regimen including dosing, duration of therapy, and route of administration¹. The benefits of ASP include improved patient outcomes, reduced adverse events, reduced unnecessary prescriptions, suppressing antimicrobial resistance emergence, improvement in rates of antibiotic susceptibilities to targeted antibiotics, controlling medical expenses, and optimization of resource utilization across the continuum of care²⁻³.

ASP in St. Paul's Hospital (SPH)

A coordinated multidisciplinary approach is essential to the success of the ASP. Several core elements contribute to the achievement of the ASP, which include: leadership commitment, drug expertise, action, tracking, reporting and education⁴.

In SPH, leadership commitments by Medical Superintendent Dr. William Ho along with Infection Control Committee (ICC) support the development and maintenance of ASP. Pharmacists serve as drug expertise to develop and manage ASP, and provide recommendations on the optimal use of antibiotics. Actions implemented by pharmacists to make interventions on the intravenous (IV) to oral (PO) switch of antibiotics to improve patient safety by reducing the unnecessary use for intravenous access. Pharmacists also track the use of antibiotics by measuring the defined daily dose (DDD) to determine the quantity of antibiotic use. The results and findings were reported periodically in the ICC meetings, Drug and Therapeutics Committee (DTC) meetings and Staff Doctors' meetings to serve as an education to physicians and nurses.

Antibiotics Intravenous (IV) to Oral (PO) Switch Program

Ideally, intravenous antibiotics should be converted to their oral forms as soon as feasible and clinically appropriate, for the sake of reducing patients' length of hospitalization, decreasing IV catheter-related complications and decreasing medication expenses. In light of its tremendous benefits and favorable outcomes observed from overseas and local clinical settings⁵⁻⁷, as well as in accordance with ACHS periodic review recommendations, Antibiotics IV to PO Switch Program has been introduced in SPH since 6th March, 2017, with an aim of antibiotics usage optimization. The development of the program has become one of the most effective strategies of achieving ASP in SPH.

The program was commenced with a 2-week observational study from 6th June to 19th June, 2016 and a subsequent 4-week interventional study conducted in the period of 3rd – 31st October, 2016. Upon completion of these two studies, "Guideline on Handling of Intravenous to Oral Switch of Antibiotics in St. Paul's Hospital" was developed and endorsed by the ICC and the DTC on 4th February, 2017. On 6th March, 2017, live run of the program with well-defined inclusion and exclusion criteria was initiated in resident medical officers (RMOs) cases with four targeted wards. The expansion of RMOs cases to all wards (except ICU and Maternity/Nursery) was completed by 26th June, 2017. Starting from 3rd October, 2017, the program has gradually rolled out to all visiting medical officers (VMOs) cases (except cases in ICU and Maternity/Nursery) and completed by 9th April, 2018.

Three targeted antibiotics (i.e. Augmentin®, Cravit® and Ciproxin®) with good oral bioavailability are included in the program. On the daily basis, pharmacists will review and evaluate the in-patient cases which were prescribed with targeted IV antibiotics. If the cases are eligible for the conversion, recommendations of IV to PO switch will be made to the corresponding prescribers using intervention letters. Upon receipt of the intervention letter, nurse conveys the letter to the corresponding prescriber at the earliest convenience. A switch to the oral antibiotics within 48 hours after issuing the intervention letter is deemed as acceptance of the recommendation.

With the efforts and collaboration of multidisciplinary healthcare professionals, a remarkable outcome of 90.8% acceptance rate in RMOs group and 88.8% in VMOs group has been achieved between 1st October 2017 and 30th April, 2018. A trend of increased cases being switched to oral antibiotics without pharmacists' intervention by prescribers (RMOs cases: 28.6% in March 2017 to 41.1% in February 2018) has also been observed, which reveals that there are raising awareness, improving surveillance and assurance of appropriate usage of antibiotics among prescribers.

Defined Daily Dose (DDD)

According to the World Health Organization (WHO), DDD is the assumed average maintenance dose per day for a drug used for its main indication in healthy adults, which is independent of price, formulation and hospital admissions, so that a comparison of standardized doses of the same drug among hospitals or different clinical settings can be made.

In SPH, ten antibiotics were classified as "Big-Gun" (BG) antibiotics for DDD



measurement, as approved by the ICC. Pharmacy has performed the review of DDD of BG antibiotics in 2014-2017 with the aims to investigate the prescribing pattern of BG antibiotics and to develop measures on promoting the optimal use of BG antibiotics in SPH, so as to reduce the spread of antimicrobial resistance.

Similar prescribing patterns were observed during 2014-2017. Invanz® was the BG antibiotic with the highest DDD/1000 Inpatient Days, followed by Meronem® and Tazocin® in 2017. The overall DDD/1000 Inpatient Days of the ten BG antibiotics has declined from 9.33 to 9.09 (2014 to 2017). The decreasing trend in the DDD/1000 Inpatient Days throughout the years reflected that the consumption of BG antibiotics has reduced, which may be contributed by the education to physicians through sharing of the findings and results in the Staff Doctors' meetings, ICC and DTC meetings to raise their awareness of optimal and judicious use of BG antibiotics.

Zinforo® Interventional Study

Zinforo® is a novel fifth generation cephalosporin which is considered as one of the BG antibiotics targeting a wide range of gram-positive and gram-negative bacteria. Retrospective annual reviews regarding the "Clinical Appropriateness of Prescribing Zinforo® in SPH" were conducted in 2016 and 2017. The annual observational reviews aim to investigate the clinical appropriateness of the prescribing of Zinforo® in SPH; to evaluate the prescribing pattern of Zinforo®; and to provide recommendations on the safe and rational use of Zinforo®. The findings and analyzed data were shared in the Staff Doctors' meeting, ICC and DTC meetings. The DDD/1000 Inpatient Days for Zinforo® has decreased from 3.33 in 2016 to 2.72 in 2017 while the appropriateness of the prescribing of Zinforo® has

increased from 16% in 2016 to 47% in 2017. The decline consumption of Zinforo® and the surge in the clinical appropriate prescribing reflected that physicians have raised the awareness of appropriate usage, attributable to the education shared in the Staff Doctors' Meetings, ICC and DTC meetings. In order to more proactively enhance the clinical appropriateness of Zinforo® utilization and to explicitly explore its underlying inappropriate prescribing practice, a interventional prospective study of the clinical appropriateness of prescribing Zinforo® was conducted in February to April 2018, with the aims to facilitate pharmacists to make interventions at the point of prescribing Zinforo® and to provide recommendation on the safe and rational use of Zinforo® in SPH.

Future Plan and Implementation

In order to have a more comprehensive review on the antimicrobial usage and prescribing patterns in SPH, the review of DDD/1000 Inpatient Days has been extended to all parenteral antibiotics in 2018, including non-BG antibiotics. The prospective study of the clinical appropriateness of prescribing Zinforo® will be an on-going study started in August 2018. Furthermore, inclusion of more targeted antibiotics (e.g. Flagyl®) will be explored to maximize the coverage of Antibiotics IV to Oral Switch Program. On-going surveillance and monitoring will be conducted and the results will be shared in various meetings to serve as an educational tool to clinicians. Continuous collaboration between multidisciplinary healthcare professionals is essential to ensure the effectiveness of ASP. Physicians play a pivotal role in the optimal prescribing of antibiotics and reduce unnecessary antibiotic use. Pharmacists would continue to streamline and provide recommendations to optimize the use of antibiotics.

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The following drugs are approved for use in St. Paul's Hospital following Drug and Therapeutics Committee meeting in August 2018:

Drugs and Strength	Indication(s)	Usual Dosage
Zerbaxa 1.5g (Ceftolozane 1g/Tazobactam 0.5g) Infusion	<ul style="list-style-type: none"> • Treatment of complicated urinary tract infections (cUTI), including pyelonephritis • In combination with metronidazole is indicated in adult patients for the treatment of complicated intra-abdominal infections 	Adult: 1.5g every 8 hours by IV infusion over 1 hour
Hexaspray (Biclotymol) Throat Spray	Acute oropharyngeal disorders	Adult and children over 30 months: 2 sprays 3 times daily for maximum of 5 days
Urief (Silodosin) Capsule 4mg	Bladder obstruction associated with benign prostatic hyperplasia (BPH)	Adult: 4mg BD after meals
Xigduo <XR> (Dapagliflozin/ Metformin) Tablet 10mg/1000mg	Type 2 diabetes mellitus	Adult: 1 tablet daily with evening meal



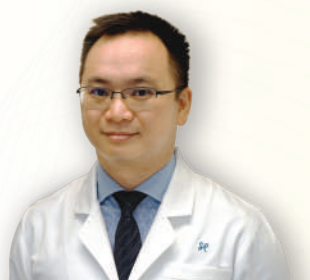
INTRODUCTION

OF NEW FACES

Hi everyone, I am Tung Lok Man, Karen. It's my pleasure to join the family of St. Paul Hospital as a surgical resident. I graduated from Chinese University of Hong Kong in 2006 and have completed my basic and higher surgical training in Pamela Youde Nethersole Eastern Hospital. I obtained my general surgical fellowship in 2014 and joined the colorectal team of PYNEH afterward. I had special interest in laparoscopic colectomy and endo-luminal surgery. And I am currently the Honorary Treasurer of the Hong Kong Society of Coloproctology. I hope I can apply what I had learnt before to help my patients.



Dr. Tung Lok Man
Staff Specialist in General Surgery



Dr. Kwong Wing Hang
Staff Consultant General Surgeon

Hello, I am Jantzen Kwong. It's my pleasure to join the family of St. Paul's Hospital. I graduated from University of Hong Kong in 1997. After internship, I have trained and worked in New Territories East Cluster for 20 years. I got my fellowship in 2005 and had overseas training of Head and Neck surgery in Taiwan in 2008. Since 2010, I have concentrated in development of endoscopic & laparoscopic skills in Upper Gastrointestinal and Pancreatico-biliary surgery. I really enjoy the working environment here and I hope to be a trusted member in the St. Paul's family.

Hi, I'm Wong Chung Ting, Martin. It's my pleasure to join the family of St. Paul's Hospital as a Specialist in Orthopaedics and Traumatology. I graduated from the University of Hong Kong in 2005 and have my training in Tuen Mun Hospital and Pok Oi Hospital. My special interest is in spinal diseases. I had my overseas training in Wakayama Medical University Hospital for Minimal Invasive Spinal surgery and Kanazawa University for spinal tumour operations. I wish I can help my patients with what I had learnt and improve the quality of service in St. Paul's Hospital.



Dr. Wong Chung Ting, Martin
Staff Consultant in Orthopaedics & Traumatology



HOSPITAL

UPDATES

St. Paul's Hospital 聖保祿醫院



全新

牙科中心及眼科中心 於本院A座繼續為您服務

Brand new **Dental Centre** and **Eye Centre** in operation in Block A

牙科中心 Dental Centre

聖保祿醫院A座二樓

2/F, Block A, St. Paul's Hospital

☎ : 2830 3710 / 2830 3718

眼科中心 Eye Centre

聖保祿醫院A座五樓

5/F, Block A, St. Paul's Hospital

☎ : 3113 4222 / 3113 4211



詳情請留意聖保祿醫院網站
For details, please refer to

www.stpaul.org.hk





ACCREDITATION

UPDATES



「澳洲醫療服務標準委員會」(ACHS)的評審工作於2018年5月進行，為期一周。評審團評核醫院的整體運作情況及服務水平。聖保祿醫院獲「ACHS醫院認證」認證年期至2022年8月。

聖保祿醫院

第二度榮獲「澳洲醫療服務標準委員會」頒發醫院認證 見證優質服務不斷求進

聖保祿醫院繼2014年獲得「澳洲醫療服務標準委員會」(ACHS)認證後，今年第二度榮獲ACHS頒發醫院認證，今次認證是按照更為嚴格的「醫院認證計劃」標準(EQuIP6)作出評審。能夠順利通過是次覆核，實在有賴全體同事於這幾年間的努力不懈和積極參與，為提升醫院服務質素而竭盡所能，同時體現團隊合作精神，認證覆核的成果無疑為我們注下一支強心針。



HOSPITAL

ACTIVITIES



聖保祿醫院

主保瞻禮日二零一八



聖保祿醫院每年均以主保聖保祿宗徒瞻禮日作為院慶，同時亦是沙爾德聖保祿女修會修女進會周年紀念及「聖保祿之友」取錄禮。為慶祝這個特別日子，沙爾德聖保祿女修會聯同聖保祿醫院於二零一八年六月二十九日下午五時，於基督君王小堂舉行感恩聖祭，由閻德龍神父主祭及多位神父共祭。

是次感恩聖祭是為慶祝黃龍秀修女、歐陽慧群修女、李金清修女及周志潔修女進會鑽禧，以及馮彩華修女及江雪萍修女進會金禧，感謝她們多年獻身修會，為社會報務。隨後舉行的「聖保祿之友」取錄禮，讓新成員在眾多嘉賓見證下，許諾成為「聖保祿之友」，追隨聖保祿宗徒的精神。



感恩聖祭參加者人數眾多，基督君王小堂坐無虛席。一眾嘉賓、修女及聖保祿醫院各部門同事，在閻德龍神父帶領下誠心祈禱。禮儀後，歐陽修女還跟現場嘉賓分享進會多年的點滴趣事，令莊嚴禮堂充滿歡樂笑聲。當日，院方更安排免費午餐及晚餐，與全院同事一起分享瞻禮日歡樂的氣氛。





CME

ANNOUNCEMENT

CME/CPD/CNE Programme 2018

New Antimicrobial Therapy in the Era of Resistant Pathogens



Speaker: Dr. Chan Kai Ming
Specialist in Infectious Disease

Chairman: Dr. Ng Yiu Ping, Angela
Staff Consultant in Respiratory Medicine, St. Paul's Hospital

Date: 15 November 2018 (Thursday)

Time: 7:00 pm – 7:30 pm Reception (light refreshment provided)
7:30 pm – 8:30 pm "New Antimicrobial Therapy in the Era of Resistant Pathogens"
by Dr. Chan Kai Ming
8:30 pm – 9:00 pm Q&A session

Venue: Meeting Room, 2/F, Block B, St. Paul's Hospital

Registration & Enquiry:
(First-come-first-serve)

Contact Person: Ms. Merrillin Leung
Tel: 2830 8857, Fax: 2837 5271, E-mail: sph.sdd@mail.stpaul.org.hk

Sponsored by:



CME / CPD / CNE Accreditation for all Colleges (Pending approval)

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Mailing Option & Personal Contact Details Update

Mailing Option Update

To reduce paper consumption and help conserve natural resources, St. Paul's Hospital encourages distribution of St. Paul's Hospital Doctors' Newsletters electronically. Doctors' Newsletters with access up to past 24 months are now available on the Hospital's website. Should you wish to refer to our electronic version of the Newsletter and stop receiving the Newsletter by post, please tick the box below and return the form to us.

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Personal Contact Details Update

To ensure you receive important updates from St. Paul's Hospital, please complete and return the following form to us (Email: vmo@stpaul.org.hk; Fax: 2837 5241) if you have updated or changed any of your previous information. Information collected will be used for Hospital communications only. Please note that it takes about ten working days to update your contact information in our system.

Personal Particulars

Name of Physician: (IN FULL NAME)

English: _____ Chinese: _____ Physician Code: _____

Correspondence (Please write down changed items only)

Address: _____

Phone: _____ Pager: _____ Mobile: _____

Fax: _____ Email: _____ Effective Date: _____

Others: _____

Signature: _____

Please return the completed form by

1) Fax: 2837 5241 2) Email: vmo@stpaul.org.hk

3) Post: 2 Eastern Hospital Road, Causeway Bay, Hong Kong (Attn: Hospital Management Department)

Thank you!