聖保祿醫院
St. Paul's Hospital

NEWSLETTER 院訊

Message from Hospital Managing Director
New Medical Governance Team

To strengthen the medical governance of St. Paul's Hospital and to enhance our commitment to patients in the ever changing medical environment, I am pleased to announce the new arrangement of our medical governance team which is led by our current Medical Superintendent, Dr. Lau Kam Ying.

The board and the hospital management team have further appointed Dr. Arthur Lee, Dr. Lee Siu Wing and Dr. Yuen Siu Tsan as Deputy Medical Superintendents.The new medical governance team will drive and strengthen the clinical governance of St. Paul's Hospital for further re-development and clinical service enhancement. The team aims to further improve risk management, fortify the hospital's accreditation programmes, and enhance communication with staff. The corporate governance body as led by our General Manager, Mr. Samuel Cheung will work together with the new clinical governance team in order to ensure effective and efficient use of resources, and most important of all to deliver the highest standard of care to patients.

With God's blessings and guidance, and the unfailing support from all staff members of St. Paul's Hospital, I am confident that their leadership and motivation would bring new impetus to St. Paul's Hospital in facing any new challenges ahead.

Sr. Nancy Cheung
Managing Director

New Medical Governance Team:

Dr. LAU Kam Ying joined St. Paul's Hospital in February 2010 as Medical Superintendent and Chief of Service of Diagnostic & Interventional Radiology Department. He is a British qualified and American board certified radiologist with a wide spectrum of clinical and administrative experience. He graduated in 1978 and worked as a general practitioner, chest physician and clinical oncologist before his radiology residency in the Princess Margaret Hospital, Hong Kong. He received 30 months' intensive overseas training in the early 90's in angio/interventional radiology (IR) and neuroradiology with 4 months in angio/IR at Westmead Hospital, Australia; 14 months in angio/IR at Toronto General Hospital; and 12 months in neuroradiology at the University of Massachusetts Medical Center.

Before joining our hospital, Dr. Lau was the Chief of Service of the Department of Radiology of Pamela Youde Nethersole Eastern Hospital (PYNEH) and the Cluster Chief of Service of the Hong Kong East Cluster. Under his leadership, PYNEH became a tertiary referring centre for angio/IR procedures, and in particular for bronchial artery embolizations. He also worked with the oncology colleagues and developed a special reporting format for MRI staging of newly diagnosed NPC to facilitate therapy.

He previously served as a director of a private hospital and school manager of an international school. Currently, he serves as a school manager of a kindergarten. He is an honorary associate professor of the University of Hong Kong, member of the Training Requirements Subcommittee of the Hong Kong College of Radiologists; member of the Society of Interventional Radiology, American Society of Neuroradiology and American College of Radiology. His research and publications are mainly in angio/interventional radiology, neuroradiology and oncology imaging categories.

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Dr. LEE Arthur graduated from Faculty of Medicine, University of Hong Kong and received his postgraduate pathology training at the University of Pittsburgh and Harvard Medical School. He was Associate Professor of Pathology at Harvard Medical School and attending pathologist at Lahey Clinic Medical Center in Boston. During his tenure in Boston, Dr. Lee was actively involved in teaching and in breast cancer research in addition to patient care activities. He was the principal investigator of two National Cancer Institute research grants supporting breast cancer research, and has published multiple scientific paper and made presentations at many international scientific meetings. He received his Doctor of Medicine degree from the University of Hong Kong with a thesis based on breast cancer biology focusing on tumor angiogenesis, lymphovascular invasion and metastasis.

After returning to Hong Kong, he has served since 1997 as consultant pathologist and Chief of Pathology Department at St. Paul's Hospital. The department has expanded under his auspices and now comprises both the Anatomical (Histopathology) and Clinical Laboratory divisions, with a staff of 3 fulltime pathologists, and over 50 technicians. He served as acting Medical Superintendent in the absence of Medical Superintendent in the period 2009-2010. He has actively participated in multiple hospital committees.

Dr LEE Siu-Wing graduated from University of Hong Kong, Faculty of Medicine in 1990. He began his surgical training in Queen Elizabeth Hospital and then United Christian Hospital. Dr. Lee subsequently received the Fellowships of the Royal College of Surgeons Edinburgh and the College of Surgeons Hong Kong in 1994, and then the Fellowship of Academy of Medicine, Hong Kong in 1998. His main interest was in the gastrointestinal surgery, in particular hepatobiliary and pancreatic surgery. In order to pursue clinical excellence, he received further hepatobiliary and pancreatic surgery training in Memorial Sloan Kettering Hospital, New York; John Hopkins Hospital, Baltimore and Nagoya University Hospital, Japan.

He joined St Paul's Hospital in 2004, and began to serve as committee members of various advisory committees and Convener of the Surgical Quality Assurance Meeting (M&M meeting). He was subsequently appointed as a member of the Hospital Management Committee and Hospital Governing Committee in 2008.

Dr. Lee said it is his great honor to be appointed together with Dr Yuen Siu Tsan and Dr Arthur Lee as Deputy Medical Superintendents. Having worked under the leadership of the two Medical Superintendents (Dr. David Fang and Dr. Lau Kam Ying), he truly appreciates the complexity and amount of the work involved, not mentioned that all of them still have their own clinical and specialty commitment. He added, to have four of them to work together is more than division of labor, the ultimate aim is to strengthen the existing clinical governance to have a clear line of accountability, continuous quality improvement and sufficient transparency to patients, staff and public. He also mentioned that this will inevitably involve some major organizational changes in order to maintain, sustain and continuously improve the quality of care provided by the hospital to the patients. These changes should also involve governing doctors who work in the hospital included the standard of care, credential of individual doctor and procedures performed. He said this is particularly important in this era of medical climate shift when more patients are expected to be driven to private market, raised patients' expectation, extensive media coverage of medical incidence, emphasis on patients' right and access to information which in the past may rightly be turned down.

Dr. YUEN Siu Tsan graduated from the University of Hong Kong with MBBS in 1984. After three years of training in various aspects of surgery and orthopaedics, he got his FRCSEd in 1989 and FCSHK in 1991. He started his training in Pathology in Queen Mary Hospital in 1988 and got his MRCPath(UK) and FHKCPath in 1993. He was admitted to the Hong Kong Academy of Medicine (Pathology) in 1995. He was granted with FRCPath(UK) in 2000. With his research and submission of thesis, he got his Doctor of Medicine (HKU) in 2003. Dr. Yuen is currently consultant pathologist at St. Paul's Hospital. He also has other appointments. He is Honorary Clinical Professor of the Department of Pathology of the University of Hong Kong, Honorary Professor of Beijing Army General Hospital, Co-Director of the Hereditary Gastrointestinal Cancer Genetic Diagnosis Laboratory in Department of Pathology of HKU and the Hereditary Gastrointestinal Cancer Registry in St. Paul's Hospital, and Medical Advisor of Hong Kong Cancer Fund. In the past, Dr. Yuen has worked as Council Member

of the University Doctors' Association and Public Doctors' Association. He has also been the Secretary of the Training and Examinations Committee, Examination Secretary and Council Member of the Hong Kong College of Pathologists. He has also been members of many Committees of Queen Mary Hospital. Dr. Yuen has received a number of awards. He is the leader of the team that was awarded the Outstanding Team Award of Hospital Authority in 2003. He and his research team were awarded twice in 2008 and 2010 the Faculty Research Output Prize (for the best published paper) of Faculty of Medicine, University of Hong Kong. Academically, Dr. Yuen publishes extensively, with 149 peer-reviewed papers, including 3 in Nature, 3 in Nature Genetics, 2 in PNAS, 1 in JAMA. He is currently amongst the world top 1% of authors in terms of total citations in the ISI Essential Science Indicators. He has been invited to lecture in many local and international organizations and conferences.

Medical Information 醫療資訊

Obstructive Sleep Apnea – An ENT Perspective

Introduction

Obstructive sleep apnea (OSA) is a condition characterized by increased airflow resistance resulting in repetitive episodes of pharyngeal collapse during sleep. It represents one end of a spectrum of clinical conditions termed sleep-disordered breathing (SDB), which range from simple snoring, through upper airway resistance syndrome (UARS), obstructive hypoventilation, to OSA.

OSA is a highly prevalent condition, especially in developed countries. It was estimated that approximately 20% of adults in the United States have OSA. In Hong Kong, a community-based survey in students from 6 to 12 years old showed that habitual snoring occurred in 11%, and the prevalence of witnessed obstructive sleep apnea was 1.5%.

Pathophysiology

Patients with OSA have nocturnal airflow restriction resulting from upper airway collapse between the nasopharynx and hypopharynx. Pharyngeal dilator muscle activity is reduced in normal and OSA individuals during sleep. However, patients with OSA have anatomically smaller upper airway and diminished pharyngeal dilator tone resulting in clinically significant airflow limitation during nocturnal negative pressure inspiration. Pharyngeal airway collapse will be even more severe in patients with co-existing nasal obstruction and obligatory mouth breathing.

Clinical features

Some of the common risk factors of OSA in adults are male sex, age>35, obesity, neck circumference >17inches, receding chin, and hypertrophic tonsils. In children, the main risk factors are obesity and hypertrophic tonsils and adenoids.

The symptoms of OSA in adults are quite different from those in children. Adult patients usually presents with snoring, snorting, excessive daytime sleepiness, and morning headache. Children may not complain of any sleepiness in the daytime. They may present with poor attention, hyperactivity, temper tantrum, poor school performance and nocturnal enuresis. Some children may have failure to thrive.

OSA may be associated with increased risk of systemic hypertension, coronary vascular disease, congestive heart failure, cerebrovascular disease, glucose intolerance, impotence, obesity, pulmonary hypertension, gastroesophageal reflux, and impaired cognitive function. It will also cause social problems such as heavy snoring, lack of energy in social interaction, and risks of dozing off during driving.

Diagnosis of OSA

A full polysomnography with attending sleep technician is the gold standard. This gives information about sleep architecture, arousal, respiratory events, oxygen saturation, sleep position, leg movement, heart rate variability, and degree of snoring. Other simplified forms of tests with fewer leads were used for screening and may be more acceptable for children or those who could not tolerate extensive wiring. There is also an expanded market for ambulatory or home monitoring.

Clinical evaluation of OSA patients

Clinical assessment includes general medical, cardiorespiratory, neurological, and airway assessment. Basic parameters include weight and height, BMI, blood pressure, and heart rate.

Airway assessment starts from evaluating the neck circumference, and the maxillary-mandibular skeletal relationship. Rhinoscopy is done to search for any cause of nasal obstruction such as deviated nasal septum, hypertrophic turbinates and adenoids. For pharyngeal assessment, the relative size of the tonsils, uvula, soft palate and tongue base are assessed. One commonly used system is the Fujita's classification which classified the obstruction into 3 types: soft palate, soft palate plus base of tongue, and base of tongue alone.

For dynamic airway assessment, fibreoptic naso-laryngoscopy with Mueller's maneuver is a quick and simple out-patient tool to identify the anatomical level of collapse. It consists of a nasopharyngoscopic assessment of the upper airway during which the patient performs a reverse Valsalva maneuver to mimic airway collapse during sleep. However, the best available method of dynamic airway assessment is sleep naso-laryngoscopy. With patient under light sedation, the level(s) of obstruction and the site(s) contributing to the snoring noise could be identified.

Fibreoptic naso-laryngoscopy and Muller's Maneuver

Management

Management of sleep-disordered breathing is multidisciplinary and usually multi-modality. These includes lifestyle and behavioural modifications, weight reduction, sleep hygiene, management of co-existing medical illness such as hypertension or cardiovascular disease, non-surgical therapy such as nasal CPAP and mandibular advancement devices, and surgical treatment. Different medical personnel would be involved in the management team, including physician, paediatrician, dentist, physiotherapist, dietitian, bariatric surgeon, and ENT surgeon.

Nasal continous positive airway pressure (CPAP)

CPAP has a major role in the treatment of SDB. It acts as a pneumatic splint to keep the upper airway patent. It is the most effective single-modality treatment of OSA, especially for severe cases and those involving multi-level obstruction. However, poor compliance is the major obstacle. Reasons of poor compliance include nasal discomfort, dry throat, air leak, pressure-related arousal, cumbersome machine, and sense of restrain. Some patients just could not accept the concept of life-long dependence on a machine. Ways to improve compliance include correction of nasal obstruction, using machine with automatic pressure adjustment and humidifying chamber, and technical support in the initial period of usage of the machine.

Surgical management for sleep-disordered breathing

Surgical treatment could be broadly classified into 2 groups, those aim for treating snoring or mild OSA, and those aim for treating OSA. For the former, the treatment should ideally be minimally invasive, could be done under LA, and office-based. Surgical success of surgery for snoring could be rather difficult to measure. For surgical treatment of OSA, success is usually defined as an AHI less than 20 and a reduction in AHI of 50% or more after surgery.

OSA surgeries can also be categorized according to the level of obstruction which it is dealing with, namely nasal, retropalatal, retroglossal, and hypopharyngeal. Surgeries for nasal obstruction include septoplasty, turbinectomy, radiofrequency turbinate reduction, turbinoplasty, etc. Nasal surgeries are sometimes performed just for facilitating the use of nasal CPAP.

Uvulopalatopharyngoplasty (UPPP) had been the mainstay of surgical treatment for OSA since its introduction in the 1950's, and had been used in many literatures as the standard for comparing surgical success in various OSA surgeries. Success rate of UPPP varies from about 40 to 80% in different literatures. It was later found that UPPP was more successful in treating patients with Fujita type I retropalatal obstruction and patients with mild to moderate OSA. Over the past decade, different types of pharyngoplasty and palatal surgeries had been developed, aiming at decreasing the morbidity associated with the more radical UPPP technique. Other palatal surgeries which aim for treating snoring or mild OSA include laser-assisted uvulopalatoplasty (LAUP), radiofrequency ablation of soft palate, and Pillar palatal implants.

Surgeries for retroglossal and hypopharyngeal obstruction include genioglossus advancement, tongue suspension, midline glossectomy, linualplasty, hyoid bone repositioning, and radiofrequency tongue base ablation (somnoplasty).

Two types of surgery which are particularly successful in severe OSA are maxillomandibular

advancement (MMA) and tracheostomy. MMA involves a sagittal split mandibular osteotomy and a Lefort I maxillary osteotomy to achieve bimaxillary advancement. It is considered a phase II surgery after failing those phase I soft tissue surgeries, but it would be the first surgical option in patients with severe mandibular deficiency. Tracheostomy is considered in those very severe cases such as patients with severe morbid obesity or severe mandibular deficiency.

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Dr. Lau Tze Wing
Specialist in Otorhinolaryngology

Presentation at a CME/CPD/CNE Meeting

The Day after Tomorrow - Consequences after Nuclear Crisis

St. Paul's Hospital, 25th March 2011

"From Radiation Protection Point of View…"

Martin Law; PhD, DABSNM
Medical Physicist, Department of Clinical Oncology, Queen Mary Hospital.

With the recent nuclear crisis in Japan, hospitals in Hong Kong should be well prepared for the situation when a large group of air passengers from Japan seeking medical advice in Hong Kong. Other possible nuclear crisis in Hong Kong may be due to the terrorist attack using dirty bomb and due to the radiation leakage from Daya Bay power plant. Hospital contingency plans, normally a team of different medical specialists, should be regularly reviewed in order to cope with nuclear crisis. These plans comprise of availability of radiation detection devices, training of hospital personnel and availability of medical care for possible patient hospitalization. Basic procedures on the detection of radiation contaminants are presented together with some general procedures to perform radiation decontamination. Wiped patient samples from ears and nostrils as well as blood and urine should also be collected to determine if the patient has been internally contaminated or not.

From radiation protection point view, the awareness of public concern in radiation dose and its risk for radiological diagnosis will be increased. It is our responsibility, as public health providers, to provide evidence based information when questions are raised from patients coming for radiological examinations. It is also our initiative to measure or literature search for such information when new imaging technique and instrument are implemented in daily practice, an example of which is the use multi-detector CT in cardiac imaging [1-2].

Another point of discussion is the personnel dose reduction for radiation workers practising radiation procedures. The principle of radiation protection of As Low As Reasonably Achievable (ALARA) is always the goal to refine our practice in order to further reduce personnel dose after knowledge and experience have been gained, an example of which is the use of radioimmunotherapeutic agent for Non-Hodgkin lymphoma patient treatment [3].

Looking into the future in the subject of radiation protection particularly in the expansion of patient service in cancer treatment and advanced imaging, its design and shielding calculation of new facilities are important not only to optimze the cost but also to protect patients and personnel from radiation exposure. A team work is necessary in such large scale project.

Reference:
*1. **Pediatric 64-MDCT Coronary Angiography With ECG-Modulated Tube Current: Radiation Dose and Cancer Risk***
Bingsheng Huang, Martin Wai-Ming Law, Henry Ka-Fung Mak, Stephen Ping-Fai Kwok, and Pek-Lan Khong. Am. J. Roentgenol., Aug 2009; 193: 539 - 544.
*2.**Radiation dose and cancer risk in retrospectively and prospectively ECG-gated coronary angiography using 64-slice multidetector CT***
B Huang, J Li, M W-M Law, J Zhang, Y Shen, and P L Khong. Br. J. Radiol. 2010 83: 152-158.
*3.**Radiation dose measurements for personnel performing ^{90}Y-ibritumomab tiuxetan administration: a comparison between two injection methods for dose reduction***
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Health Risk after Radiation Exposure

Dora Kwong, MBBS, MD, FRCR, FHKCR, FHKAM

Professor and Head, Department of Clinical Oncology, The University of Hong Kong.

The recent nuclear crisis in Fukushima raises concerns over the health risk of radiation exposure. Radiation is ubiquitous in our environment and we make use of them in everyday living. There are two main types of radiations: non-ionizing radiations such as light and radio waves and ionizing radiations such as X-rays and Gamma rays. It is mainly ionizing radiation that is of health concern. Ionizing radiations have enough energy to rid electrons from atoms or to break molecular bonds to cause formation of free radicals. These free radicals will disrupt DNA of cells to cause DNA breakage. High dose of radiation will disrupt DNA beyond repair and cause cell death. This will lead to the acute damage of tissue or death of the organism depending on the dose and biological effect of radiation concerned. Cells that are exposed to low dose radiation can repair the DNA damage. However, mishaps in cellular repair of DNA will cause mutation which accounts for the carcinogenic, tetratogenic or genetic effect of radiation. The health effects of radiation are divided into two types: stochastic and non-stochastic effects. Stochastic effects are caused by long-term, low dose exposure and consist of the carcinogenic, genetic effects of radiation. Stochastic effects does not have threshold of development. Non-stochastic effects are caused by acute, high dose exposure. Different tissue has different threshold which needs to be exceeded to develop non-stochastic effect. Non-stochastic effects are mainly observed in those who are directly exposed at the site of nuclear accident or more commonly seen in patients who receive high dose radiation for treatment of cancers.

In nuclear accidents, people in direct exposure to high dose radiation will develop acute radiation syndrome. The higher the dose of radiation exposure, the shorter is the time to onset of the syndrome and the more severe will be the syndrome. For people who are exposed to more than 2Gy radiation, they will develop haematopoietic syndrome which indicates bone marrow failure. Mortality rate is high but they may be salvaged with blood transfusion, G-CSF support and bone marrow transplant. Gastrointestinal syndrome occurs if radiation dose received is more than 10 Gy and central nervous system syndrome develops when radiation dose received is more than 30Gy. Both gastrointestinal and neurological syndromes are uniformly fatal. Stochastic effects are the main concerns to populations exposed to the radionuclides carried off in the radioactive plumes. The younger is the person at the time of radiation exposure, the higher will be the risk of development of cancer. The incidences of leukaemia, lymphoma and thyroid cancers rose within a few years in previous atomic bomb and Chernobyl nuclear accident survivors. The basic principles of evacuation, sheltering and food, milk, water monitoring should be used to protect the public from stochastic effects. Iodine pills may be used as an adjunct to these measures to block the thyroid uptake of iodine 131 in population which has significant exposure to I131.

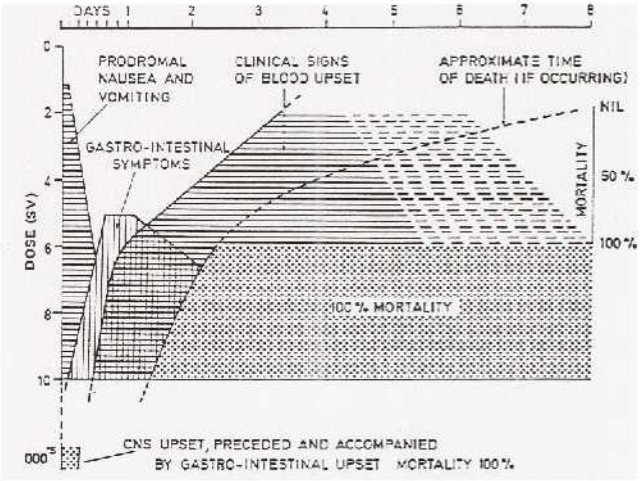
For protection of personnel who may handle radiations, the type of radiation concerned is important. There are two types of ionizing radiations: particular radiation and photons. Particular radiation consists of subatomic structures such as alpha, beta and neutron particles which correspond to proton, electron and neutron in atoms. Particular radiation has a finite range of penetration depending on the energy of the particles. On the other hand, photons (X-rays and Gamma rays) are electromagnetic radiation and they follow the inverse square laws, i.e. the intense of radiation is inversely related to the square of the distance from the source. In general, photons are much more penetrating than particular radiation but the biological damages caused by particular radiation are more severe than photon. Thus, particular radiations usually will only damage tissues in direct contact with these radiations. However, photon can cause damage at a much longer distance from the source and will need thick lead shielding for protection.

In nuclear accidents, patients can be irradiated due to external irradiation by gamma rays or there may be external contamination by radionuclides on skin or clothing or internal contamination with radionuclides that are ingested or inhaled. Patients suspected of radiation exposure should be screened and monitored for radiation exposure. Patients or materials exposed to photons do not carry residual radioactivity and thus is not of danger to those who serve them. External contamination can be dealt with by removing contaminated clothing and repeated washing. Internal contamination would need drug treatment which increases the elimination

of the contaminating radionuclides from the body. For patients who are contaminated with gamma emitting radionuclides such as iodine 131, they are radioactive. Personnel who handle them should adopt the basic rules of distance, time and shielding to avoid excess exposure. Universal protective measures such as gloves, disposable gown and face shield will avoid cross contamination between patients and carers.

Radiation Doses and Dose Limits

Flight from Hong Kong to New York	70 μSv
Annual public dose limit	1 mSv
Annual natural background in HK	2 mSv
Fetal dose limit in HK	1 mSv
Barium enema	8.7 mSv
Annual radiation worker dose limit	20 mSv
Heart catheterization (skin dose)	450 mSv
Life saving actions guidance(NCRP-116)	500 mSv
Mild acute radiation syndrome	2 Sv
$LD_{50/60}$ for humans (bone marrow dose)	3.5 Sv
Radiation therapy (localized & fractionated)	60 Sv



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Q & A Session with
Dr. Ma Shing Yan as facilitator

Dr. Martin Law &
Dr. Dora Kwong delivered the talk

Sourouirs presented by
Dr. K.Y. Lau

Over 70 professionals attended the seminar

In Loving Memory of Dr. Emmanuel Chang

永遠懷念陳樂彬醫生

1929-2011

On 2nd April 2011, a requiem mass was held in Christ the King Chapel of St. Paul's Convent for the late Dr. Emmanuel Chang who passed away peacefully a week earlier at the mature age of 82.

Dr. Emmanuel Chang was born in Seychelles where he received his early education in French as well as English and Chinese. Later he came to Hong Kong and graduated from the University of Hong Kong with M.B.,B.S. in 1954. He served successively in Queen Mary Hospital, Tsan Yuk Hospital and Tung Wah Hospital before setting up a busy and successful private practice in North Point. Being a devoted catholic he soon developed a close tie with St. Paul's Hospital as a visiting doctor. Because of his proficiency in the French Language his service was particularly appreciated among the French community. In the 1950s and 1960s, St. Paul's Hospital also had the service of Dr. SC Chang who spoke Spanish, Dr. Vio who spoke Italian and of course Sir Albert Rodrigues who spoke Portuguese in addition to English and Chinese, offering a truly international health service – long before Hong Kong developed the concept of an international city.

Dr. Emmanuel Chang also contributed his valuable time and service to the Hong Kong Medical Association, serving as honorary secretary and treasurer and actively promoting its membership. For years he was Master of the Guild of SS. Luke, Cosmas and Damian where he rallied catholic doctors to spiritual and moral betterment in the true healing spirit of Christ. He was always kind and gentle towards his patients and colleagues. In particular he was generous with his advice to juniors and new comers to the field of medical practice. Fifty years ago, when medical litigation was still a rarity, he repeatedly warned that doctors should be extra cautious about what to administer to the patients, and that if anything goes wrong the dissatisfaction could turn into a vicious counter response. To-day, on looking back, his warning seems virtually prophetic.

We shall remember Dr. Emmanuel Chang as a model of a good doctor, a good catholic and a good man. We shall remember him in our prayers. May God's light continue to shine upon him and may he rest in His eternal peace.

ME/CPD/CNE Programme

Program Announcement

Date:	14th July 2011 (Thursday)	19th July 2011 (Tuesday)
Topic:	**Do's & Don'ts in Medical Legal Proceedings**	**Orthopaedic Foot Problems** 1. Hallux Valgus Managements 2. Lessor Toe Deformities 3. Plantar Fasciitis
Speakers:	1. Dr. Chiu Shing Ping, James *Specialist in General Surgery* 2. Ms. Lisa De'Ath *Solicitor*	1.Dr. Ngai Yiu Hing, William *Specialist in Orthopaedics & Traumatology, St. Paul's Hosptial* 2.Dr. Law Yee Cheong, Wally *Specialist in Orthopaedics & Traumatology* 3.Dr. Chan Tun Kut, Roger *Specialist in Orthopaedics & Traumatology*
Chairman:	Dr. Lee Siu Wing *Specialist in General Surgery*	Dr. Chien Ping, Eric *Specialist in Orthopaedics & Traumatology*
Time:	7:15pm-9:00pm(Light refreshment provided at 6:45pm)	7:30pm-9:00pm(Light refreshment provided at 7:00pm)

Venue: Conference Room, 2/F, St. Paul's Convent
Registration & Enquiry: Ms Sally Pun, Tel:2830 3905, Fax:2837 5271, E-mail:sally.pun@mail.stpaul.org.hk
CME/CPD Accreditation for all Colleges (Pending approval). CNE Point :1 Point

Hosptial update 醫院動態

Live Surgery Demonstration on Minimally Invasive Gynaecology (MIG) at St. Paul's Hospital – a first time and a beginning…

The 5th China-Australia-Asia Pacific Minimally Invasive Gynaecology Forum meeting was held at the Regal Hong Kong Hotel, from 7-9 May 2011. St. Paul's Hospital (SPH) was one of the organizing partners in this meeting. At the opening ceremony, Professor Felix Wong (Chairman of the organizing committee) and Dr. Lau Kam Ying (Medical Superintendent of SPH) welcomed up to 200 delegates from Korea, Japan, Australia, America, Hong Kong, Taiwan and China. After two days of exciting and stimulating didactic lectures at the hotel, around 20 Chinese and overseas delegates attended a half day live surgery demonstration in St. Paul's Hospital on 9th May 2011 .

There were two operations for live surgery demonstration - a laparoscopy myomectomy and a single port laparoscopic hysterectomy. The two surgeries were performed by Dr. Chau Wing and Dr. Chan Kuen Ting assisting each other. Both of them are experienced laparoscopists known in St. Paul's Hospital and are known experts in the field. As suturing is an important part of laparoscopic surgery, a laparoscopic myomectomy procedure would require high skill to demonstrate the suturing technique. Dr. Chau Wing skilfully demonstrated his suturing technique and performed a tying knot which he had invented and used over the years. This knot enables a secure and tight knot to be applied to the myomectomy wound for good haemostasis, when the surgery is only performed by a single surgeon without any assistant. The two surgeons had also managed to remove several large fibroids through a single myomectomy wound – not an easy task. The other surgery was a single port surgery which was a recent development of less invasive approach of the laparoscopy surgery. The laparoscopic surgery was only performed through a single umbilical wound of 1.5 cm, instead of 3-4 wounds of 0.5 to 1 cm, with the advantages of less pain, less infection and cosmetically more acceptable. Despite it was a difficult surgery, Dr. Chan Kuen Ting completed the hysterectomy procedure satisfactorily via a single umbilical port.

The two surgeons received applauses several times from the attending delegates who watched these procedures at a distance away via video conference. During the meeting, a lot of questions had been raised by the attending delegates. Dr. Paul Yuen Tak Ho, the chief moderator at the lecture room helped to explain to the Chinese and overseas delegates about these surgeries and coordinated the questions and answers for the myomectomy case and Dr. Leslie Lo for the single port case.

A short visit of the hospital was arranged with visits to Maternity Wards, Diagnostic & Interventional Radiology Department and Cardiac Centre etc. Delegates were very happy and enjoyed this guided tour at St. Paul's Hospital. A Chinese delegate commented that Hong Kong doctors and their patients were like working and staying in heaven as compared to their working environment in the crowded and busy hospitals in China. All delegates were very impressed with the surgical skills of our Hong Kong doctors. They would like to have more communications and exchanges with doctors from St. Paul's Hospital in the future and if possible, to refer patients to Hong Kong for these minimally invasive surgeries.

A note of thanks would also be given to Dr. Lau Kam Ying who welcomed the delegates, and to SPH staff for their great support. Finally a big thanks to the permission and support from the senior Hospital administration and the sisters of St. Paul de Chartres. The MIG members would extend their warm welcome for their presence and support at the live surgery demonstration, which would mark the beginning of a new era prior to the future development of SPH.

MIG Advisory Panel
St. Paul's Hospital

Prof. Felix Wong and Dr. Lau Kam Ying welcomed delegates at the opening ceremony on 7 May 2011

High resolution live surgery demonstration at St. Paul's Hospital chaired by Dr. Paul Yuen Tak Ho.

Dr. Chau Wing and Dr. Chan Kuen Ting took photos with a group of visiting Chinese and overseas delegates after live surgery demonstration

A Solution for Discharged Elderly Patients

"Ageing in place" is the wish of most elderly people. In the Chinese culture, taking care of parents at home is a reflection of filial piety. However, longer life-span prolongs the caring period. Haven of Hope Christian Service (HOHCS) commissioned the Sau Po Center on Ageing of the University of Hong Kong (SPCOA) to conduct a study aimed to investigate how the family members of those elders with changes in their health status handle such changes and understand the stresses the family members face. Titled "Unexpected Health Change of Elderly and Stress on Family Members Study", the survey was carried from April to August 2010. Four private hospitals participated in the study; one of these was St. Paul's Hospital. 537 respondents were successfully interviewed. Below is the summary of the study's results:

Summary of Survey Results

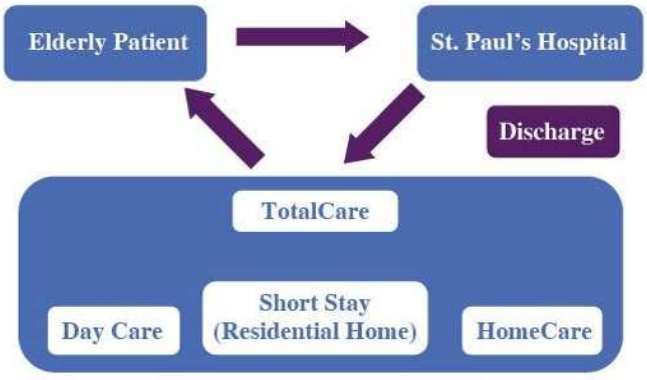
1. Over 65% of the respondents spend $4,000 or above per month in care services for their elderly family members at home.
2. There is a general lack of elderly care knowledge and information of their elders among the carers with over 34% of the respondents indicating that they lack such knowledge and that support to carers is also inadequate.
3. About half of the respondents expressed that their domestic maids are not fully capable of taking care of their elders.
4. A majority of the respondents indicated that in taking care of the elderly, the pressure on their time is the greatest, followed by pressure on their physical health and daily life (e.g. adversely affecting their social life).
5. Such pressure on family members who live with their elders is greater than that on family members who do not live with their elders.

TotalCare – a newly launched service of HOHCS

Seeing the inadequate community support for discharge elderly patients, Haven of Hope Christian Service (HOHCS) launched a new service, namely "TotalCare", for these service users. TotalCare is a one-stop service for elderly people with long-term illnesses requiring care. Integrating the Primary Health Care and Community Health Care models, services are rendered with the objective of improving the medical, nursing and rehabilitation care of the elderly people. The services of TotalCare are delivered through case management and include Service Enquiry and Referrals, Medical, Nursing, Rehabilitation and Personal Care Services at the elder's home, day centre or residential care home, training courses for carers and domestic maids.

Collaboration of St Paul's Hospital and TotalCare for discharge elderly patients

Elderly people are sent to the hospital for various reasons. It is difficult for family members to take care of personal care needs, and especially when there are also rehabilitation and/or special nursing needs at discharge. St Paul's Hospital and TotalCare collaborated together to work out a mechanism for discharge elderly patients. Physicians and nurses of St Paul's Hospital could make referrals to TotalCare for the discharge of their elderly patients. Family members and their elders could choose home care service, day care or residential care as appropriate. If they are waiting for a new domestic maid, TotalCare service could send personal care and/or rehabilitation staff to take care of the elderly at home during the waiting period. When the domestic maid arrives, TotalCare can provide training for the maid. As appropriate, TotalCare staff can either continue to liaise with St Paul's Hospital on the medical care needs of the elder, or if medical care is completed, TotalCare can refer the elder back to St Paul's Hospital when medical consultation is required.



TotalCare provides a comprehensive array of services for discharged elderly patients. We hope our service could serve these elders and their family members.
For enquiry, please call 2663-3001.

total care 靈實 全護通

聖保祿醫院LED屏幕照亮大地

位於本院A座大樓頂層的大型LED屏幕已於四月二十日開始投入運作。LED屏幕樓高兩層，不單在維多利亞公園及本院鄰近地區顯而易見，遠至銅鑼灣海旁、甚至紅磡體育館都清晰可見。LED屏幕採用尖端的透光媒體立面照明技術，可播放動畫，將主愛世人及醫院之訊息傳揚開去，以發揚「承傳天恩，活現主愛，迎向未來」的偉大精神。

Outreach activities 外展活動

聖保祿醫院之病人資源中心春節聯歡會於二零一一年一月二十二日在一片歡呼聲中舉行。在聯歡會中除了匯報2010年活動，展望來年活動外，更頒發義工獎狀表揚各位義工在這一年內對社會的貢獻及熱誠。

本中心與嶺南衡怡紀念中學聯合舉辦免費長者健康檢查服務。此次活動是由本院一羣義工學護教授嶺南衡怡紀念中學多達二十五位中四至中六學生，量度血壓、心跳及計算身體質量指數(BMI)的知識和技巧。其後，熱心學護更帶領義工同學分別於二月二十六日及六月二十五日到小西灣進行兩次長者日健康檢查外展活動，每次活動替多達一百名長者進行身體檢查。

本中心於三月六日與離島婦聯坪洲婦女中心合辦免費健康檢查活動。當日本院派出由四十多名醫生、護理人員、學護和義工組成的外展團隊，前往坪洲為五百名長者及島上居民作身體檢查，包括量度血壓、脂肪測試、尿液測試、骨質密度測試、乙型肝炎測試、膽固醇測試、肝/膽超聲波掃瞄及眼科檢查等，並有護士在場解答健康問題，藉此向當地居民推廣注重身體健康之訊息。

此外，本中心於四月十日與九龍金域扶輪社及旺角街坊福利會合辦醫療外展活動。本院共派出四十一位義工及三名醫生，全日共替五百九十六名長者及獨居老人提供免費身體檢查，包括量度血壓、脂肪測試、尿液檢查等。

Hosptial activities
醫院活動

四旬期退省活動後記

醫院周年退省活動已於四月七日在赤柱瑪利諾神父修院舉行，時間由上午九時至下午四時，出席人數共有四十七位。在乘坐專車啟程前往的路途上大家一起恭唸玫瑰經，在活動中有個人靜默及祈禱時刻、修和聖事、感恩聖祭、拜苦路及神父專題講座等，當天的退省活動流暢及充實。

關傑棠神父在講道中刷新我們的思維，好讓大家能用新的態度進入退省，引領我們在寧靜中與主相遇，並勉勵大家在個人及團體中恆常祈禱，多行愛德服務及在生活中多行克己、守齋善功，有助我們在不同的工作崗位上發顯同理心，善度四旬期偕主同行，活出主愛的精神。

在教友年的講題中，關神父主動地分享了自己聖召的歷程，藉此喚醒大家同樣地肩負著君王、司祭及先知的職務。福傳我，我福傳，把福音的喜訊帶給尚未認識主基督的人。

在結束當日的活動中，我們懷著感恩的心情聚合一起拍照留念，祝願未有出席參與的弟兄姊妹們，都能分享我們的平安和得著。

牧靈部 陳慧芳