"I made myself all things to all men" (1 Cor. 9:22)
" 我為一切人成為一切" (格前 9:22)

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聖保祿醫院
St. Paul's Hospital

NEWSLETTER 院訊

Message from the Hospital Management

It is with much honour and gratitude but also with deep humility that I assume my appointment as Deputy Medical Superintendent. I have had the good fortune of serving as Chief of Pathology at St. Paul's Hospital since 1997 after returning from the USA. I am very grateful for the opportunity now to serve St. Paul's Hospital from an additional perspective. To whom much is given, much is expected. I also feel humbled by the appointment because of the high expectations and the daunting challenges of the position.

It is my honour to serve along with Dr. Lee Siu Wing and Dr. Yuen Siu Tsan as Deputy Medical Superintendents under the leadership of our Medical Superintendent Dr. Lau Kam Ying. Our team's mandate is to strengthen clinical governance and enhance standard of care. I believe that the responsibilities of each team member will be complementary, and that the sum of the team will be greater than its parts. I also anticipate a beneficial synergy between the medical governance team and the corporate management team. The Hospital has entrusted me with the chairmanships of the Clinical Audit Committee and the Public Communications and Education Advisory Panel, and I also anticipate contributing to areas related to quality and risk management. The support and advice of Hospital staff and visiting doctors in these areas will be eagerly sought and deeply appreciated.

The last few years have witnessed momentous changes at St. Paul's Hospital. To wit, they include the redevelopment project, the Hospital Information System, and the introduction of numerous measures instrumental in building a strong clinical and corporate governance framework. The implementation of such changes is critical in achieving efficient care and patient safety that meet international standards. Needless to say, the speed and scope of these changes have exacted a toll on our staff. However, we trust that they will understand these changes are important and essential, and that the Hospital, the staff and patients will all stand to benefit. At this juncture, the Hospital is entering a phase of consolidation and digestion of the many implemented measures, and the benefits are beginning to be realized. Coupled with the completion of Block B Building in 2014, we may be confident of a modern Hospital with a pleasant, safe and ergonomic work environment, state of the art equipment and a dedicated and well-trained staff, all within a framework of stringent clinical and corporate governance and Catholic spirit. The seeds have been sown and the foundations laid for the future. We extend our sincere thanks to our dedicated, selfless and loyal staff whom I trust will continue to contribute in a harmonious manner. We may be assured that the best is yet to come for St. Paul's Hospital.

Hong Kong is currently at a critical cross road for healthcare delivery and financing. The changing dynamics between the public and private sectors pose a serious challenge for private hospitals. The Government is in the process of devising a viable long term healthcare financing scheme. The rising cost of healthcare is creating havoc worldwide for healthcare financing. The burden is upon private hospitals to adjust in order to meet these challenges and to provide safe and affordable health care. We need to be motivated, creative and resilient to prevail in our quest to be an exemplary hospital, while bearing in mind our mission as a compassionate and caring institution.

Dr. Arthur Kai-Chung Lee
Deputy Medical Superintendent

St.Paul's Hospital
2, Eastern Hospital Road,
Causeway Bay, Hong Kong
Tel: 2890 6008
Fax: 2576 4558
Website:www.stpaul.org.hk

聖保祿醫院
香港銅鑼灣東院道2號
電話: 2890 6008
傳真：2576 4558
網址:www.stpaul.org.hk

Medical Information 醫療資訊

Prolotherapy/ Regenerative Injection Therapy in Musculoskeletal Medicine

Soft tissue musculoskeletal pain is extremely common and represents a significant medical and financial burden to society. Over 100 million musculoskeletal injuries occur annually worldwide, with 30-50% involving soft tissue, tendon and ligament injuries.

Concept of Natural Wound Healing

On a cellular level, soft tissue wound healing after acute injury is initiated by an inflammatory healing cascade, in which numerous growth factors and cytokines induce macrophage and fibroblast activity, leading to new extracellular matrix and collagen fibre formation. This inflammatory phase lasts 4-6 days, after which the concentrations of inflammatory mediators drops rapidly. In contrast, areas of chronic tendon injury as seen in histological studies are devoid of inflammatory changes, and thus exhibit more of a degenerative condition, known as tendinosis.

Principle and Mechanism of Prolotherapy / Regenerative Injection Therapy

Prolotherapy has been practiced since 1937 and is a medical procedure to treat musculoskeletal or joint pain. The principle of prolotherapy is to inject the proliferant in the form of either concentrated glucose solution or other growth factor production stimulants (hence the term Prolotherapy) or in form of the patient's own blood or platelets concentrate (hence the term platelet rich plasma prolotherapy, commonly known as PRP) to stimulate the body's growth as well as its healing mechanism to repair injured tissues.

The basic mechanism of Prolotherapy is directed towards the actual augmentation of tissue healing via bioactive substances that increase the local concentration of the same growth factors involved in tissue repair or involve sclerosis of pathologic neovessels associated tendinosis. By injecting a proliferant or growth factors to the areas of chronic tendon, ligament and joint injuries, the body's own healing system would be activated to stimulate a short-term inflammatory reaction in the body. This localized inflammation triggers a wound healing cascade, attracting the fibroblasts which deposit new collagen -- the building block of ligaments and tendons. New collagen shrinks as it matures and this shrinking collagen tightens the ligament and makes it stronger.

Application of Prolotherapy to Chronic Pain

Prolotherapy can strengthen ligaments and enthesis (the region where the ligament attached to the bone). In theory, all joints that are supported by ligament can be treated with prolotherapy. The limitation is mainly anatomical, when the joint is not assessable because it is either too deep or is covered by blood vessels or nerve tissues, e.g. the intervertebral discs. Areas of the body that can be treated with prolotherapy include the head, neck and temporomandibular joints (TMJs); the spine, sacroiliac joints and pubic bones; the shoulders, elbows, wrists, hands and fingers; the hips, knees, ankles, feet and toes and a myriad of other areas.

Treatment Sessions of Injection

For a typical treatment session, it takes approximately 20 - 60 minutes, including preparation, procedure and recovery time. Prolotherapy may be carried out as outpatient or inpatient. Most patients are able to return to their work and usual activities one or two days after the procedure. Initially, there will be mild swelling and stiffness after prolotherapy injections. Some patients notice improvement in one to two weeks after the first treatment. Most patients will realize increasing improvement with each successive treatment. Research studies show that over 80 percent of people treated with prolotherapy report a good or excellent result. Many of them are permanently cured. Not only do they enjoy simple pleasures again – a good night's sleep, sitting through a movie, taking a walk – but many also return to physical activities such as soccer, hill walking, jogging, skiing and even back onto the waveboard.

Multiple treatments are required to restore additional tissue growth and to strengthen the affected area. The number of treatment sessions varies with each patient. Many patients have reported partial or complete relief of pain after only one treatment. Patients with a healthy immune system generally require fewer treatments. Studies show that an average person requires 4 to 6 treatment sessions given at 4 to 6 week interval in order to get a satisfactory healing. The current data accumulated by the HKIMM (The Hong Kong Institute of Musculoskeletal Medicine) showed that Chinese patients usually need 3-4 treatments for satisfactory pain relief.

Effectiveness and Safety of Prolotherapy

The effectiveness of prolotherapy does depend upon the technique of the injecting prolotherapy physician. The injection sites must be very accurate as the physician needs to inject adequate amount of the proliferant (prolotherapy solution) into the injured and weakened area. Many evidence based studies demonstrated mostly positive outcomes for chronic neck pain, cervical spinal instability, chronic thoracic pain, chronic low back pain, sacroiliac dysfunction, coccygodynia, chronic groin pain, knee osteoarthritis, medical collateral ligament sprain, patellar tendinosis, Achilles tendinosis, medial and lateral epicondylosis and finger osteoarthritis.

Prolotherapy is a safe procedure. There is, of course, at least a slight risk involved as in any other medical procedure. Similar to any injection, prolotherapy theoretically could cause bleeding, damage nerve, lead to after-pain, or introduce infection. However, these risks are extremely small comparing to the risk of long term consumption of anti-inflammatory drugs (NSAIDs) or pain killers to alleviate the chronic pain. Although data regarding safety are limited, a large scale survey of prolotherapy practitioners found the treatment to be safe for back and neck pain, with a safety profile similar to other widely used spinal injection procedures.

Factors affecting Progress of Prolotherapy

Studies showed that the following 4 categories of patients are more likely to have poor results / slow progress from prolotherapy.

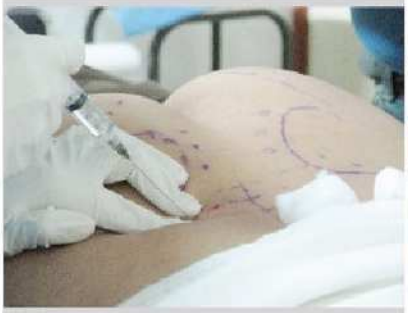
1) Those have poor sleep, problems in sleep initiation, fragmented sleep, or those who wake up feeling un-refreshed: Growth factors and growth hormones are crucial factors for proper tissue healing. Studies showed that growth factors and growth hormones are released and secreted mostly during the deep sleep phase of the sleep cycle. Those patients with poor or frequently inadequate sleep tend to have poor response or slow progress from prolotherapy.

2) Those have hormonal imbalance: Apart from growth hormones, there are other hormones in our body which are crucial for proper tissue healing. Examples are sex hormones and thyroid hormones.

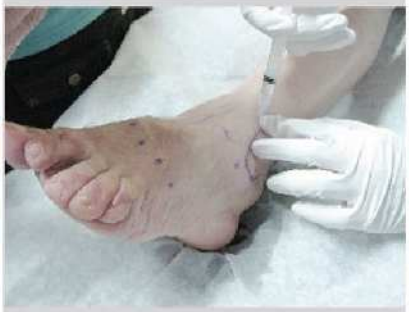
3) Those have nutritional imbalance: The healing of our body needs nutrient, especially collagen. Those patients with nutrition deficiency in essential amino acids and fatty acids will be slow in healing. Some studies show that blood PH influences the healing process. Imbalance diet may lead to altered blood PH and deter the response to prolotherapy.

4) Those patients not receiving adequate proliferants (prolotherapy solution) injected into the injured areas: The effectiveness of prolotherapy depends on whether the injured area received enough injected proliferants to trigger off the body's repair process in the area. The response also depends on whether the patient received adequate number of treatment sessions.

Dr. Lee Wang Yat, Paco
Specialist in Family Medicine



Prolotherapy to lumbar spine and sacroiliac joint



Prolotherapy to ankle joint

Prolotherapy of lumbrosacral spine to patient in Mexico in 2010

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Presentation at a CME/CPD/CNE Meeting
持續醫學進修講座

Gastrointestinal Stromal Tumor (Review & Update) St. Paul's Hospital, 17th May 2011

Radiological Diagnosis

Dr. Chan Kam Wai, John
Specialist in Radiology
Diagnostics & Interventional Radiology Department
St. Paul's Hospital

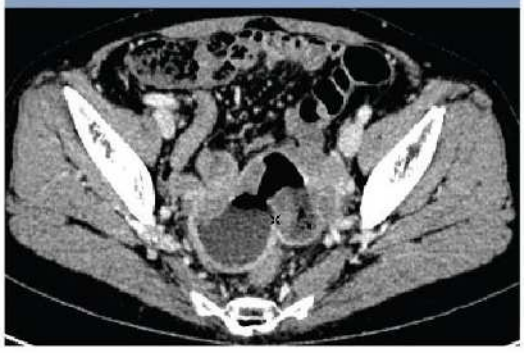
Abstract:

The presentation is talking about the radiological diagnosis for GIST tumor, the imaging findings of the differential diagnosis and paradoxical findings after Imatinib treatment in good response cases. Imaging parameter to predict the aggressiveness of the GIST is also included in the presentation.

GIST is the most common mesenchymal tumor in abdomen. Common sites of involvement are stomach and small intestine. GIST at stomach and small intestine are often benign. For those in colon, rectum and esophagus are more likely to be malignant.

Exophytic or extra-serosal extensions are common features. Communication or fistula between the GIST and the stomach or small intestine are often seen (Fig. 1). Calcifications and lymph node metastasis are unusual features for GIST.

Fig. 1: Small intestinal GIST in a female and air fluid level in the pelvic mass, suggestive of fistula with small bowel.



Size is one of the important parameter to predict the aggressiveness of the tumor. Tumors less than 2cm are usually benign.

Adenocarcinoma is one of the differential diagnosis for GIST but they rarely have significant exophytic or extra-serosal components.
Lymphoma is another important differential diagnosis and it can look exactly same as GIST and it is difficult to distinguish from GIST (Fig. 2). Histological diagnosis is recommended.

In some occasion, metastasis can also simulate GIST (Fig. 3). Liver and peritoneum are common sites of metastasis or recurrence.

Imatinib is the drug of choice to treat GIST, particularly for those with metastasis. In contrast CT scan, inhomogeneous contrast enhancement is usually seen in GIST. In good response cases, the tumor should become homogeneously hypodense without contrast enhancement.

However, even in good response cases, some paradoxical imaging findings like temporary tumor enlargement and ascites are noted and these findings can simulate tumor progression. Thus, during imaging follow-up, careful analysis of the serial images are necessary.

Fig. 2: Two different patients in fig. 2a and 2b.

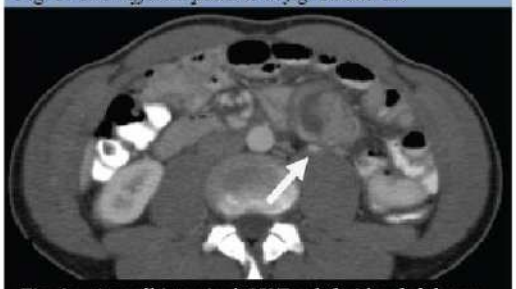


Fig. 2a: A small intestinal GIST at left side of abdomen with small extra-serosal component (white arrow).

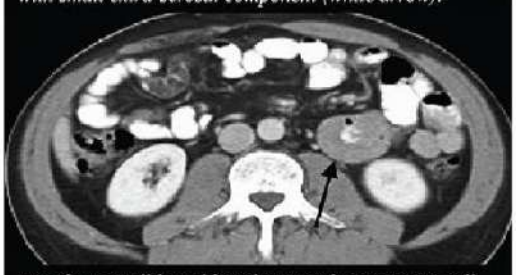


Fig 2b: A small bowel lymphoma with concentric wall thickening and tiny gas bubble at the wall in another patient (black arrow). Radiologically, it cannot be distinguished from GIST.

Fig. 3: A patient with history of colonic carcinoma and found to have recurrence.

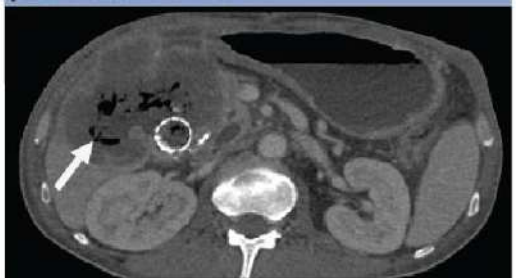


Fig. 3a: Axial contrast CT scan image reveals a duodenal mass encasing the duodenal stent with multiple intra-tumoral gas pockets (white arrow), suggestive of fistula. This appearance simulates fistula seen in GIST.

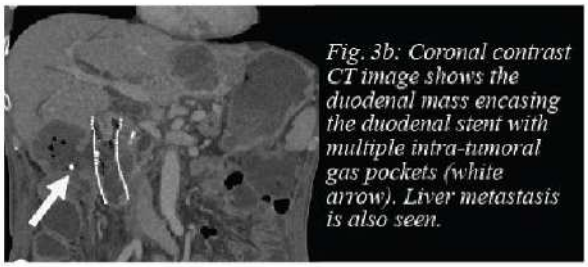


Fig. 3b: Coronal contrast CT image shows the duodenal mass encasing the duodenal stent with multiple intra-tumoral gas pockets (white arrow). Liver metastasis is also seen.

Fig. 3c: 3D volume image of the duodenal mass (blue color) and liver metastases (yellow and green color)

Pathology Review

Dr. Yuen Siu Tsan
Consultant Pathologist
Department of Pathology
St. Paul's Hospital

Introduction

Gastrointestinal stromal tumor (GIST) is the most common mesechymal tumor in GIT. According to autopsy study, approximately 22% of individuals over age 50 have small GIST around 1 to 10mm. Majority of GIST are located in the stomach, which accounts for 60% of cases, 30% are found in jejunum and ileum, 5% in duodenum, 4% in colorectum, and the remaining are in extra-gastrointestinal site. GIST is said to arise from interstitial cells of Cajal (ICT) or showing differentiation towards ICT. Recently the identification of driving mutations in KIT, PDGFRA and BRAF has enabled a better understanding of the pathogenesis of GIST.

Broadly speaking, taking into consideration of the molecular genetics and the clinical features, there are five categories of GIST.

1. KIT mutated GISTs – account for the majority of GIST and are found at different anatomical sites and, include the rare familial GIST
2. PDGFRA mutated GIST – associated with gastric location, epithelioid features and favorable outcome
3. BRAF mutated GIST (small number) – associated with small bowel location and high risk tumor
4. Paediatric GIST – associated with Carney's Triad or Carney's Dyad.
5. NF-1 associated GIST – lack kinase mutations and usually follow a favorable clinical course

KIT and PDGFRA in GIST

KIT mutation is the most common mutation found in GIST. KIT exon 11 mutations occur throughout the GIT GIST. Mutations in exon 9 are most common in GIST in small intestine. GIST with KIT exon 9 mutataions are more aggressive than those with KIT exon 11 mutation.

Overall 8% of GIST show PDGFRA mutation. These are mostly in exon 18, and rarely in exons 14 and 12. Mutation in PDGRFA is associated with GIST in stomach and omentum and these tumours lack KIT protein expression. PDGFRA mutants are less aggressive than those with KIT mutation.

Immunohistochemical Markers

95% of GIST express KIT. For the remaining ones that are negative for KIT, it is a diagnostic challenge for pathologist. Other commonly expressed markers may help. These include CD34, h-caldesmon, and SMA. Rare markers include desmin, S100, cytokeratin, and recently new markers like DOG1 (1/3 KIT -ve), nestin, carbonic anhydrase II (1/2 KIT –ve). Consideration may also be given for mutation analysis for these KIT –ve tumours.

Determination of biological behavior

It is now clear that the biological behavior of GIST depends on both the tumour parameter including the size and the mitosis, and the location of the tumour. The table in the following page highlights the risks of progressive disease in various categories of GIST. More recently, there is a new 2010 TNM classification for GIST. Although potentially useful, it raises several controversies.

Molecular testing for GIST

Molecular testing for GIST is useful in certain situations. Firstly, it is useful for diagnosis for those KIT-negative GISTs. Secondly, it provides prognostic data for some of these tumours. Thirdly, the molecular data have implication for adjuvant treatment for intermediate-high risk GISTs and for primary treatment for non-resectable/metastatic GISTs.

Conclusion

GIST is now a well-defined tumor. Underlying genetic event is the mutation of KIT, PDGFRA or BRAF. Exact morphological classification and pathology risk assessment is an essential part for optimal patient care. Molecular testing is potentially of value in certain situations in a subset of GIST.

Table: Pathology risk assessment for GIST

Tumor parameter		Risk of progressive disease (metastasis or tumour related death)			
Mitosis/50HPF	Size (cm)	Gastric	Duodenum	Jejunum/ileum	Rectum
≤ 5	≤ 2	None	None	None	None
≤ 5	> 2 to 5	Very low (1.9%)	Low (8.3%)	Low (4.3%)	Low (8.5%)
≤ 5	> 5 to 10	Low (3.6%)	High (34%)[a]	Moderate(24%)	High (57%)[a]
≤ 5	> 10	Moderate (12%)	High (34%)[a]	High (52%)	High (57%)[a]
> 5	≤ 2	None[b]	No cases	High (50%)[b]	High (54%)
> 5	> 2 to 5	Moderate (16%)	High (50%)	High (73%)	High (52%)
> 5	> 5 to 10	High (55%)	High (86%)[a]	High (85%)	High (71%)[a]
> 5	> 10	High (86%)	High (86%)[a]	High (90%)	High (71%)[a]

[a] *Two groups were analysed together because of low case numbers*
[b] *Low case number*
(Adapted from Miettinen et al, Semin Diagn Pathol 2006;23(2):70-83.)

Surgical Treatment of Gastrointestinal Tumor

Dr. Lee Siu Wing
Specialist in General Surgery
St. Paul's Hospital

Before the era of imatinib, R0 surgical resection was the only effective treatment that can be offered to the patients. Imatinib has however revolutionized the approach of treatment towards GIST. The role of surgical resection needed to be redefined.

Patients with primary localized resectable GIST; the mainstay treatment is still complete surgical resection with a clear margin. Tumor that has involved or adherent to the adjacent organs should be resected en-bloc with the tumor, in order to avoid capsule rupture and intra-abdominal spillage. Unlike the well defined role of lymphadenectomy in gastric adenocarcinoma, GIST metastasize only rarely to local regional lymph node and lymphadenectomy should only be considered when there is obvious LN involvement detected intraoperatively.

Routine neoadjuvant or preoperative imatinib are not considered necessary, and should only be considered in the context of medical research. Primary localized "unresectable" GIST or GIST situated at site for which surgery would lead to a major functional loss (e.g. low rectal GIST mandating AP resection), imatinib can be given preoperatively to downsize the tumor to achieve a R0 resection or surgery can then be performed with important functional preservation. Typically, surgery should be considered after 4-6 months of treatment and during this period of time, tumor response should be closely monitored with PET CT scan.

Patients presented with relapsed or metastatic GIST, the first line of treatment should be target therapy with imatinib.

Palliative surgical interventions are indicated for patients with replased or metastatic GIST presented with complications such as viscus perforation, bleeding, hemorrhage or gastrointestinal obstruction.

Role of surgical intervention in "asymptomatic" patients with relapsed or metastatic GIST are however not well defined.

1) Patients with diffuse progression of disease while on imatinib should not be considered for salvage surgery as these patients invariably fair poorly after surgery unless symptoms or complications dictate otherwise.

2) Patients with stable disease or limited progression of disease while on imatinib response favorably to surgically debulking or resection of any residual disease with a prolonged overall and progression free survival. Surgical resections in this scenario carry the theoretical benefit of reducing the tumor load and removing the imatinib resistant tumor clone. However, whether the overall favorable outcome is a result of natural selection or benefit derived from surgical resection as such, is not certain.

Oncological Treatment

Dr. Ma Shing Yan
Specialist in Haematology & Haematological Oncology
St. Paul's Hospital

Before the era of targeted therapy, the treatment of choice for GIST was limited especially in metastatic cases or surgically-unfit patients. Traditional chemotherapy is effective in 5% cases only and radiotherapy resulted in high morbidity. Later, approximately 85% of GISTs are found to have oncogenic mutations in the genes for either of two receptor tyrosine kinases: KIT (75–80%) or PDGFR-α (5–10%). Targeted therapy has revolutionalised the whole treatment paradigm of GISTs afterwards.

Imatinib:

Imatinib mesylate, a selective inhibitor of KIT and PDGFR, is recommended for the first-line treatment of KIT-positive GIST in (1) unresectable and/or metastatic cases and (2) as adjuvant after surgery.

In unresectable and/or metastatic cases:

2 large studies, EROTIC 62005 (N=946) in Europe and Australia and Intergroup S0033 Study in US and Canada (N=746), compared 400mg/d vs 800mg/d in the management of unresectable and/or metastatic GIST patients showed similar results. Crossover was allowed in patient with progressive disease from standard dose to higher dose group. The 2 year overall progression free survival PFS and the overall response rate ORR were similar in both group, about 45% and 50% respectively. One third of patient with progression in standard dose benefited from escalating to higher dose. In general, 800mg/D is well tolerated but grade 3/4 side effects were higher.

Mutation status:

Kit and PDGFRA mutation are common in GISTs and the best clinical predictor to response to imitinib. 3 prognostic groups can be defined by their responses to imitinib: a) KIT exon 11-favourable response (PR in 61-83%); b) KIT exon 9 – intermediate response (PR in 29-47%); c) wild type or PDGFRA D842V low response (OOR 0-25%). Exon 9 mutation tends to be biologically more aggressive. Genetic profiling may be a useful tool to determine the malignant aggressiveness and tailor the best treatment for individual patients.

Side effects:

Treatment with imatinib is generally well tolerated and most adverse events (AEs) include gastrointestinal or intra-abdominal haemorrhages, diarrhoea, nausea, bloating, peripheral edema and cytopenia. Grade 3/4 AEs are usually less than 5 %.

Adjuvant chemotherapy after surgery:

In a large scale ACOSOG Z9001 study including 713 patients receiving Imatinib 400 mg as adjuvant therapy after surgery, the 1 year PFS was significantly longer than placebo (98% vs 83%, p<0.01). However, there was no difference in OS between 2 groups. A longer follow-up is likely required to observe differences. Less than 10 % required stopping imatinib due to side effects. Small bowel location (p=0.0267, HR 2.08), tumor size (p=0.0026, HR1.7), mitotic rate (p<0.001, HR17) and presence of KIT exon 11 mutation (p=0.042, HR2.97) were significant predictors of RFS in the placebo group.

Latest NCCN guidelines in 2010 :

NCCN recommended surgery as first line if feasible. The goal is to achieve complete gross resection with an intact pseudo-capsule and minimal surgical morbidity. If surgical morbidity would be improved by reduction of tumor size, neoadjuvant treatment with imatinib should be considered. Adjuvant imatinib (400mg/d) for at least 12 months should be considered in patients with immediate to high risk GIST. The optimal duration has not yet been determined and patients at higher risk may justify a longer course of therapy.

Sunitinib:

Before the introduction of sunitinib, there was no efficient systemic treatment for patients with metastatic GIST failing imatinib 800 mg/day. In a phase III study of 312 patients with imatinib-resistant or -intolerant GIST, sunitinib 50 mg/day demonstrated superior efficacy compared with placebo in an interim analysis. Median TTP was 27.3 weeks for sunitinib-treated patients and 6.4 weeks for placebo-treated patients [HR 0.33 (95% CI 0.23–0.47); P <0.0001]. Patients receiving sunitinib achieved median PFS of 24.1 weeks compared with 6.0 weeks for those receiving placebo [HR 0.33 (95% CI 0.24–0.47); P < 0.0001]. In addition, sunitinib treatment resulted in improved OS compared with placebo [HR 0.49 (95% CI 0.19–0.83); P = 0.007], although median OS could not be calculated at the time of analysis. Treatment-related AEs were generally mild to moderate in intensity; grade 3–4 AEs observed in sunitinib-treated patients included fatigue (5%), hand–foot syndrome (4%), and diarrhoea and hypertension (3% each).

Conclusion:

Targeted agents have revolutionized the treatment of advanced GIST. Studies are ongoing to elucidate the effects of imatinib and sunitinib in GIST patients according to mutational status and in alternative dosing and combination therapy regimens. Several established and novel multitargeted agents are also under investigation, which may expand the range of treatment choices available in the future for patients with advanced GIST.

Gastrointestinal Stromal Tumor (Review & Update)

Opening speech by the Chairman, Dr. Taw Jin Liam

Q & A Session with Dr. Taw Jin Liam as facilitator

Around 60 professionals attended the seminar

Presentation by Dr. Yuen Siu Tsan & Dr. Lee Siu Wing

Souvenir presentation to speakers by Dr. Lau Kam Ying, Medical Superintendent: Dr. Chan Kam Wai, John & Dr. Ma Shing Yan

CME/CPD/CNE Programme 持續醫學進修概覽

Program Announcement		
Date:	20th September, 2011	18th October, 2011
Topic:	**Updates on Breast Cancer Surgery** *1. Endoscopic Breast Surgery* *2. Updates on Sentinel Sode Biopsy*	**Practical Skills in Laparoscopic Surgery** *1. Laparoscopic Dissection of the Uterine Artery and Ureter* *2. Laparoscopic Suturing Skill in Laparoscopic Myomectomy – Wing Knots* *3. Abdominal Lifting Approach of Laparoscopic Surgery*
Speakers:	1. Dr. Choi Lai Yin, Catherine *Specialist in General Surgery, Paragon Clinic Surgical Centre and Union Hospital* 2. Dr. Suen To Ki, Dacita *Associate Consultant, Department of Surgery, Queen Mary and Tung Wah Hospitals*	1. Dr. Yuen Tak Ho, Paul *Specialist in Obstetrics and Gynaecology* 2. Dr. Chau Wing *Honorary Consultant in Obstetrics and Gynaecology, St. Paul's Hospital* 3. Professor Wong Wu Shun, Felix *Specialist in Obstetrics and Gynecology and Conjoint Professor, The University of New South Wales, Sydney*
Chairman:	Dr. Wong Ting Ting *Specialist in General Surgery*	Dr. Chan Kuen Ting *Honorary Consultant in Obstetrics and Gynaecology, St. Paul's Hospital*
Time:	7:30pm – 9:00pm (Light refreshment provided at 7:00pm)	7:15pm – 9:00pm (Light refreshment provided at 6:45pm)
Venue: Registration & Enquiry:	Conference Room, 2/F, St. Paul's Convent 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**	

Outreach Activities 外展活動

聖保祿醫院之病人資源中心於二零一一年六月十九日與屯門區婦女會合辦外展活動。當日，本院一共有四十一人出席此活動，包括醫生、修女、義工、醫護人員及學生，為六百名屯門區街坊及長者免費進行身體檢查，包括骨質密度測試及肝/膽超聲波掃描等。當日，本院醫生更為市民舉行心臟科及耳鼻喉科醫學講座。

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，本院派出一名註冊護士及五名護理系學生義工，於六月二十五日，帶領嶺南衡怡紀念中學的中四至中六義工同學，到小西灣為長者進行量度血壓、測試脂肪等身體檢查項目，並解答長者問題，是次活動多達一百名長者參與。

義工們雀躍萬分


為長者量度血壓

除熱心服務本港居民外，本中心的外展活動更遍及澳門。於七月二十四日，本中心與澳門社會服務中心合辦一年一度之健康檢查服務，多達四十名本院熱心醫生、醫護人員、學護及義工參與。沙爾德聖保祿女修會何美蘭省會長與聖保祿醫院管理層亦前往澳門出席，全力支持此活動。義工們除替六百名澳門街坊及長者量度血壓、進行尿液檢查、脂肪測試等檢查外，亦替數十名市民進行超聲波檢查，包括量度頸動脈血管壁內層厚度、腹部超聲波、及婦女盤腔子宮內膜厚度超聲波檢查。


沙爾德聖保祿女修會何美蘭省會長獲頒發感謝獎狀，以表揚省會長在過去多年來的鼎力支持。

本院管理層與病人資源中心義工接受澳門社會服務中心頒發感謝狀

本院放射科醫生、放射師及眼科醫生接受感謝狀


舉辦單位及義工們大合照


義工們為參與體檢的澳門居民進行尿液檢查


本院醫護人員在場解答澳門居民的健康問題

Hospital activities
醫院活動

聖保祿醫院主保瞻禮日

湯漢主教與眾沙爾德聖保祿女修會修女合照

聖保祿宗徒為本院之主保，每年本院均以他的瞻禮日作為本院之院慶。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二零一一年六月二十九日下午五時，於基督君王小堂舉行感恩彌撒，由湯漢主教主祭及多位神父共祭。

當日亦同時舉行沙爾德聖保祿女修會修女之進會週年感恩禮，慶祝陸明珠修女進會鑽禧，張燕容修女、高寶儀修女及劉惠雪修女進會金禧。隨後更舉行聖保祿之友收錄禮。

感恩聖祭多達數以百人出席，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，在湯漢主教帶領下一同誠心祈禱。禮儀後，眾人與四位進會鑽禧及金禧的修女一同切蛋糕慶祝和拍照留念，場面溫馨愉快。大家聚首一堂，享用自助美食，感謝上主的恩典。當日，院方更安排免費午膳及晚膳，與全院同事一起分享瞻禮日歡樂的氣氛。

湯漢主教與沙爾德聖保祿女修會何美蘭省會長及四名進會鑽禧和金禧修女合照

湯漢主教與聖保祿之友合照

湯漢主教與沙爾德聖保祿女修會何美蘭省會長與四名進會鑽禧和金禧修女切蛋糕慶祝

眾人誠心祈禱

醫院員工聚首一堂

來賓享用修會款待的自助美食

聖保祿醫院健康服務助理員畢業典禮

聖保祿醫院於二零一一年六月二十九日舉行健康服務助理員(HCA)畢業典禮，共有九名完成培訓的學員畢業。畢業典禮由本院執行董事張柱見修女頒發畢業證書，本院總經理張文景到場恭賀畢業學員，並與學員一同拍照留念。九名學員接受為期一個半月的健康服務助理員訓練課程，課程內容理論與實踐兼備，由來自多個不同專業的資深護理人員負責教授，期望畢業學員若日後投身醫護行業，能學以致用，服務病人。畢業典禮後設有茶點招待，嘉賓與師生一同歡聚及拍照留念。

Introduction of new faces 員工動態

Ms. Christine Liu
Manager of Health Information & Records Department

After almost 13 years study and work aboard, I returned to HK in 2010. As a degree holder of Health Informatics from University of Sydney and some further education on Health Service Management, I am fortunate to join the family of St. Paul's in March this year. Before that, I was working in one of the HA hospital for a short period of time. I was lucky to be given an opportunity to lead a small lovely team in the Health Information & Records Department (HIRD).

I am most delighted to face different challenges and treasure every opportunity to enhance my practical skills and knowledge in the private health industry.

It's been a pleasure to join the big happy family of St. Paul's and looking forward to enjoy our achievements in the near future.

Thanks for your Professional Service!

International Nurses Day

12th May 2011

聖保祿醫院
St. Paul's Hospital